NATIONAL SOCIAL SECURITY & WELFARE CORPORATION

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FORM B26 ACCIDENT REPORT FROM EMPLOYER

This form must be completed and sent to the appropriate office of the Corporation.
Within 48 hours of the accident being reported to you, if the injured person is likely to suffer permanent disablement or death
Within 14 days of the accident being reported to you in other cases
Where possible the form should be accompanied by the following: a Medical Certificate and Claim Form for whichever benefit is claimed

Form providing details of the injured person's earnings (except where only a claim for medical expenses is being made)

It is an offense under the Social Security Act to fail to report an accident to the Corporation within specified time limits

PLEASE TYPE OR USE BLOCK LETTERS in answering the following questions

PART 1 DETAILS OF EMPLOYER

Name of Employer	Industry	Employer Code No.
Address of Employers	P.O. Box No	Telephone No.

PART 2 DETAILS OF INJURED PERSON

Full Name	Date of Birth	Social Security No.
Address	Sex (M, F)	Occupation
Department/Shift Working Location	Works No. (If any)	Date of Starting Employment

Do you agree that this person was your employee at the time of the accident? Yes ☐ or No☐ If No give further details

_____

_____

Please turn over

PART 3 DETAILS OF ACCIDENT

Date	Time	Location of Accident

2a Exactly what was the injured person doing at the time of the accident?_____

_____

2b Was this something which he was authorized to do in connection with his job? Yes☐ or No☐ If No give further details_____

_____

3 If the accident did not happen on your premises please explain why the injured person was there?_____

_____

4a Between what hours was the injured persos supposed to work on the day of accident?_____

_____

4b Between what time did he start work in that day_____ and what time did he finish work? _____

_____

5a Describe briefly how the accident happened _____

_____

5b Name and address of witnesses (2 if possible) _____

_____

5c When was the accident reported to you? | | | |

6a Nature and extend of injury (e.g. Loss of finger, fracture,etc.)_____

6b Has the injured person returned to work? Yes ☐ or No ☐ If YES give date | | | |

6c If the injured has died give date of birth | | | |

6d Name of the physician dispensary or hospital from whom or where the injured person received or _____

Is receiving treatment_____

7 Are you paying wages to the injured person while he is absent from work? Yes ☐ or No ☐

I certify that to the best of my knowledge and belief the above particulars are correct in every respect.

Temporary Disablement Benefit

Wishes to claim Medical Benefit

Death Benefit

Permanent Disablement Benefit

Signature_____Date_____

Position_____Employers Stamp_____