

WORKMENS COMPENSATION NOTIFICATION FORM

TO BE FILLED BY THE EMPLOYER

This Form Must Be Completed and Returned Within Five Days of the Accident or Disease

Employer: _____

Address: Town _____ S/City _____ Woreda _____ H. No. _____

Tel. _____

Activity: _____ Policy No. _____

Name of the injured person (in full) _____

Date of Birth: _____

Category of work _____ Registration No. _____

Date of accident: _____ Place of Accident _____

When was the employer informed of the accident? _____ Time of the accident: _____

Brief description of the accident _____

Daily Wage Birr _____

Monthly Salary Birr _____

Employer's stamp and signature

Witnesses

Name

Signature
