ECS.BF01

FEDERAL REPUBLIC OF NIGERIA

NIGERIA SOCIAL INSURANCE TRUST FUND (NSITF)

(Employees' Compensation Act, 2010)

Notification of Accident/Occupational Disease/Death

(Section 4(1) & 5(1) of the Act)

Instruction: Complete the Form in triplicate and in block letters or mark 'x' as appropriate

Indicate as appropriate: Accident: ☐ Occupational Disease: ☐ Death: ☐

1.0 **Employer:**

Name: ☐☐

Registration No.: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

2.0 **Employee (certified copy of Identity documents to be attached):**

Surname: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐ First Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Middle Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Earnings of employee at the time of accident (attach copy of payslip as at time of accident)

N	K

Period in your employment (years ..../ months ....)

3.0 **Accident:**

3.01 Date of accident:(dd/mm/yyyy) ☐☐☐☐☐☐☐☐ 3.02 Time: ☐☐☐☐☐

3.03 Place of accident: ☐☐☐☐☐☐☐☐☐☐ 3.04 Local Govt Area: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

3.05 State: ☐☐☐☐☐☐☐☐☐☐☐ 3.06 Date employee reported accident:(dd/mm/yyyy) ☐☐☐☐☐☐☐☐

3.07 Time: ☐☐☐☐☐ 3.08 What task was the employee performing at the time of accident? ....

....

3.09 Was the accident in course of his/her work? Yes ☐ No ☐

3.10 State nature of injury sustained(see options attached)...

....

3.11 Was first aid given in this case? Yes ☐ No ☐ 3.12 State the name of the medical practitioner who treated the employee: Surname ☐☐☐☐☐☐☐☐☐☐☐☐☐ First Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Middle Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

3.13 If you have already paid or spent money on first aid/treatment to the employee, state the total amount:

.... *(attach hospital bill)*

3.14 For what period were such payments made? From(dd/mm/yyyy): ☐☐☐☐☐☐☐☐ To: ☐☐☐☐☐☐☐☐

3.15 Number of days per month worked by the employee: ☐☐☐

3.16 Date on which the employee ceased work due to injury/occupational disease(dd/mm/yyyy) ☐☐☐☐☐☐☐☐

3.17 Did the employee complete his/her shift on the day that he/she ceased work? Yes ☐ No ☐

3.18 Date on which the employee resumed work:(dd/mm/yyyy) ☐☐☐☐☐☐☐☐ Time: ☐☐☐☐☐

(If the employee will be off duty for an extended period, an interim Medical Report must be submitted regularly) 3.19 Did the employee die in the accident? Yes ☐ No ☐

3.20 If yes, name his registered dependants with you: Surname: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

First Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Middle Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

4.0 **Occupational Disease:**

4.01 Nature of work:.....

4.02 Nature of disease:.....

4.03 Date the disease was diagnosed(dd/mm/yyyy) ☐☐☐☐☐☐☐☐

4.04 Suspected cause of disease:..... (state the agents present in the work place and with which he had contact that caused the disease; see list of approved diseases and their responsible agents as contained in the First Schedule of the Act for guidance)

4.05 For how long was he exposed? Year(s)☐ Month ☐ Day☐

4.06 Date employee reported the disease (dd/mm/yyyy) ☐☐☐☐☐☐☐☐

4.07Did the employee die as a result of the disease? Yes ☐ No ☐

4.08 If yes, name his registered dependants with you: Surname: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

First Name:☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Middle Name:☐☐☐☐☐☐☐☐☐☐☐☐☐☐

4.09 Please, mention the name(s) and address(es) of former employers if the employee did not contract the disease in your employment: .....

.....

DECLARATION BY EMPLOYER OR AUTHORIZED PERSON

I hereby declare that the particulars, shown above are to the best of my knowledge true and accurate.

Signed on this ..... day of ..... 20 .....

Name of Authorised Person	Signature	Date

Tel: + 234-9-2911810; + 234-9-2911811; email: info@nsitf.net; website: www.nsitf.net