ECS.CCF01

FEDERAL REPUBLIC OF NIGERIA
NIGERIA SOCIAL INSURANCE TRUST FUND (NSITF)
(Employees' Compensation Act, 2010)
[Section 5(1) – (3) of the Act]

Notification of Accident/Occupational Disease/Death

Case ID														

Instructions: Complete the Form in Triplicate. Use block letters or mark 'x' as appropriate. All fields are mandatory.
Indicate as appropriate: **Accident:** ☐ **Occupational Disease**: ☐ **Death**:☐

1.0 Employer:

Name																											
Registration Number																											

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

Surname																			
First name																			
Middle name																			

2.1 Staff ID Number

Staff ID No.																			

2.2 Earnings of employee at the time of accident
(Attach copy of pay slip as at time of accident)

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3.0 Accident:

3.01	Date of accident dd/mm/yyyy																				
3.02	Time of accident (24 hour; hh: mm)																				
3.03	Town where accident occurred																				
3.04	Local Govt. Area																				
3.05	State																				
3.06	Date Employee reported accident dd/mm/yyyy																				
3.07	Time reported (24 hour; hh: mm)																				

3.08 What task was the employee performing at the time of accident? ________________________________

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

3.10 State the nature of injury sustained (see options attached) ____

____

3.11 Was first aid given in this case? Yes ☐ No ☐

3.12 Medical practitioner who treated the employee:

Surname																			
First name																			
Practice No																			

3.13 Number of days per month worked by Employee: ☐☐

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

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

(If the Employee will be off duty for an extended period, an interim Medical Report must be submitted regularly)

3.16 Did the Employee die in the accident? Yes ☐ No ☐

3.17 If yes, name his registered dependant(s) with you:

Surname																			
First name																			
Middle name																			

*(Attach list if more than one registered dependants)

4.0 Occupational Disease

4.01 Nature of Work:____

4.02 Nature of Disease:____

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

4.04 Suspected cause of disease:____

(State the agent(s) present in the work place and with which he/she had contact that caused the disease; see list of approved diseases and their responsible agent(s) as contained in the first schedule of the ECA for guidance)

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

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

4.07 Did the Employee die as a result of the Occupational Disease? Yes ☐ No ☐

4.08 If yes, name his registered dependant(s) with you: (Attach list if more than one dependent)

Surname																			
First name																			
Middle name																			

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

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

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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 Authorized Person	Signature& Stamp	Date

FOR OFFICIAL USE ONLY

Received and checked by:	_________________________	_________________	_________________
	Name	Staff No	Sign and Date