FEDERAL REPUBLIC OF NIGERIA

NIGERIA SOCIAL INSURANCE TRUST FUND (NSITF)

(Employees' Compensation Act, 2010)

1. Resumption Report for Accident/Occupational Disease
2. Claim for loss of Productivity

Claim No.

N.B.: This form must be completed and submitted by the employer as soon as the employee resumes work or is discharged. If on prolonged treatment, medical progress reports must be submitted regularly until such the employee is discharge or returns to work.
2. To be completed for loss of Productivity

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1. Indicate whether Accident: ☐ **or** **Occupational Disease:** ☐

2. Indicate whether Resumption Report ☐ **or** **Loss of Productivity** ☐

1. Full Name of Employee: Surname: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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

2. Employer Number:

3. Employer Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

4. Date of Accident/Occupational Disease: (dd/mm/yyyy)

4.1 State the periods(s) the employee was off duty or performing light duty	From.	To.	Advances/salary paid to the employee for the periods indicated in the item 4.1.
	Date (dd/mm/yyyy)	Date (dd/mm/yyyy)	
a). PERIOD(S) OFF DUTY.			
b). PERIOD(S) PERFORMING LIGHT DUTY.			

5. Period admitted in the hospital: From: ☐☐☐☐☐☐☐☐ To. ☐☐☐☐☐☐☐☐

6. Date of Resumption: (dd/mm/yyyy) ☐☐☐☐☐☐☐☐

I hereby declare that the particulars furnished in the foregoing report are true and correct.

Authorized signatory ______________________

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

Position: ______________________ Date (dd/mm/yyyy): ☐☐☐☐☐☐☐☐
