FEDERAL REPUBLIC OF NIGERIA

NIGERIA SOCIAL INSURANCE TRUST FUND (NSITF)

(Employees' Compensation Act, 2010)

[Section 5(1) – (3)]

NOTIFICATION OF ACCIDENT/OCCUPATIONAL DISEASE/DEATH/DISABILITY

Case ID														

Instructions: *i. Use block letters or mark " √ "as appropriate*
ii.. All fields are mandatory.

*Indicate as appropriate: **Injury:** ☐ **Occupational Disease:** ☐ **Death**: ☐ **Disability**: ☐

1.0 *EMPLOYER:

Name																												
Registration Number																												

2.0. *EMPLOYEE: ***(Copy of Identity documents to be attached)***

Surname																	
First name																	
Middle name																	
Staff ID No.																	
National ID No. (NIN)																	

2.1. *Earnings of employee at the time of accident
(Attach copy of pay slip as at time of accident)

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3.0. *INJURY:

3.01	Date & Time *(24hour)* of Accident	D	D	/	M	M	/	Y	Y	Y	Y		&		H	H	:	M	M				
3.03	Town where Accident occurred																						
3.04	Local Government Area																						
3.05	State																						
3.06	Date & Time Employee reported accident	D	D	/	M	M	/	Y	Y	Y	Y		&		H	H	:	M	M				

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: _____

_____

4.0. *Was First aid given in this case? Yes ☐ No ☐

5.0. *DEATH: *(Where applicable)*

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

(Attach the Medical certificate of cause of accident)

5.1 *Registered Dependant:

5.2.	Surname																
5.3.	First name																
5.4.	Middle name																
5.5.	Date of Birth	D	D	/	M	M	/	Y	Y	Y	Y						

5.6. *Gender: M: ☐ F: ☐

6.0. *OCCUPATIONAL DISEASE: *(Where applicable)*

6.1. Nature of Work: _____

6.2. Nature of Disease: _____

6.3. Date the disease diagnosed: D D M M Y Y Y Y

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

6.5. Date Employee reported the disease: D D M M Y Y Y Y

6.6. Date of Onset of Occupational Disease: D D M M Y Y Y Y

6.7. Date of First Consultation: D D M M Y Y Y Y

6.8. Describe the causative substance of Occupational Disease.

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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 of Receiving officer (Branch Manager) *Staff No.* *Sign&Date*