

DECLARATION BY EMPLOYER OR AUTHORISED PERSON

I hereby declare that the particulars, shown in items 1 to 40 of this report, of an alleged occupational disease contracted by the employee, are to the best of my knowledge and belief true and accurate

Signed on this _____ day of _____ 20____ SIGNATURE _____

EMPLOYER

1. Registered name with the Compensation Commissioner _____
2. Registration number of this business with the Compensation Commissioner
3. Contact person _____
4. Street address _____
5. Postal address _____
6. Postal code _____
7. Postal code _____
8. Tel (____) _____
9. Fax (____) _____
10. Situation of business/farm _____
11. Nature of business, trade or industry _____

EMPLOYEE

12. Surname _____
13. First names _____
14. Id. No. _____
15. Date of birth ____ / ____ / ____
16. Sex male/female
17. Marital state married/single _____
18. Citizen of _____
19. Personnel No. _____
20. Occupation _____
21. Street address _____
22. Postal code _____
23. Period in your employ (years/months) _____
- 24 Is the injured employee a working director, working member of a CC, owner of or a partner in the business? _____

OCCUPATIONAL DISEASE

25. Nature of disease _____
26. Date the disease was diagnosed _____
27. Alleged cause of disease _____

(State the agent present in the work-place and with which he had contact that caused the disease)
28. For how long a period was he exposed _____
29. Date employee reported the disease _____
30. Please mention the name and address of the employer if the employee did not contract the disease in your employment

