Social Security Board
P.O. Box 698
Road Town, Tortola
Virgin Islands
Tel:1-284-852-7800/Fax: 1-284-494-6022
Email: info@bvissb.vg/Website:www.bvissb.vg

EMPLOYMENT INJURY ACCIDENT REPORT

(This form must be completed by the Employer in Capital Letters)

KINDLY PRESENT DETAILED INFORMATION

EMPLOYEE DATA

NAME OF EMPLOYEE: _____SOC.SEC. NO. _____

MAILING ADDRESS: _____

DATE OF BIRTH: _____/_____/_____ OCCUPATION _____
DAY MONTH YEAR

EMPLOYMENT DATA

NAME OF EMPLOYER_____

MAILING ADDRESS _____

TYPE OF BUSINESS _____

EMPLOYER REGISTRATION NO. ☐ **TELEPHONE NO.** ☐

Email Address_____

PARTICULARS OF ACCIDENT

DATE OF ACCIDENT _____/_____/_____ TIME OF ACCIDENT: _____ A.M.
DAY MONTH YEAR _____ P.M.

DID ACCIDENT HAPPEN DURING WORKING HOURS? YES ☐ NO ☐

ON WHAT DATE WAS THE ACCIDENT REPORTED TO THE EMPLOYER? _____/_____/_____
DAY MONTH YEAR

WAS THE EMPLOYEE ENGAGED IN HIS/HER NORMAL DUTIES AT THE TIME OF THE ACCIDENT?

YES ☐ NO ☐

IF NO, WHAT WAS THE PURPOSE OF BEING AT THE PLACE OF THE ACCIDENT?

_____

FULL ADDRESS OF PREMISES WHERE ACCIDENT OCCURRED:

_____

WHAT INJURIES WERE SUSTAINED AS A RESULT OF ACCIDENT? _____

_____

WHERE WAS THE INJURED EMPLOYEE TAKEN? _____

DID THE EMPLOYEE WORKED DURING THE INJURY PERIOD? YES ☐ NO ☐

IF YES, STATE PERIOD: _____

GIVE CLEAR DETAILS OF THE CAUSE OF THE ACCIDENT: (use separate paper if more space is needed)

_____

_____

_____

_____

_____

_____

_____

NAME AND ADDRESS OF WITNESS TO THE ACCIDENT: _____

_____

WHERE WAS THE WITNESS IN RELATION TO THE INJURED? (describe approximately how many feet away)

_____

IF INJURY OCCURRED WHILE TRAVELLING, STATE

A) PLACE OF EMBARKATION _____

B) DESTINATION _____

C) WAS TRANSPORTATION OWNED/RENTED BY EMPLOYER? YES ☐ NO ☐

D) IF NO, WAS PERMISSION GIVEN BY EMPLOYER TO USE TRANSPORTATION? YES ☐ NO ☐

_____

NAME OF MANAGER/SUPERVISOR (PRINT)

_____ _____

SIGNATURE OF MANAGER/SUPERVISOR **DATE**

COMPANY STAMP