



**SECTION 1: TO BE COMPLETED BY THE EMPLOYEE / SELF EMPLOYED**

Surname

N.I.S #

First Name

Gender  Male  Female

Marital Status Married  Divorced  Single

Date of Birth   
YYYY MM DD

Address

Telephone Number

Parish

Home

Mobile

Occupation

Work

Date Last Worked   
YYYY MM DD

Name of Bank  Address

Account Number

I hereby declare that the information given is true and correct.

Claimant's Signature.....

Date:   
YYYY MM DD

**SECTION 2: TO BE COMPLETED BY A REGISTERED DOCTOR**

I certify that ..... is incapable of work by reason of

..... from  to   
YYYY MM DD YYYY MM DD

Doctor: Surname:

First Name:

Reg. No:

DOCTOR'S STAMP HERE

Signature .....

Date:   
YYYY MM DD

**SECTION 3: TO BE COMPLETED BY EMPLOYER**

Employer's / Business Name .....

Employee's commencement date:   
YYYY MM DD

Telephone Number

Business Address

This employee will be losing earning? Yes [ ] No [ ]

BUSINESS  
STAMP HERE

Employer's Signature.....

Date:   
YYYY MM DD

**SECTION 4 : TO BE COMPLETED BY THE EMPLOYER**

*Please note that this section is to be filled out for both sickness benefit and employment injury benefit.*

State monthly/ weekly rates of pay for the 8 week period immediately before the week in which the incapacity started.

FROM (yyyy/mm/dd)	TO (yyyy/mm/dd)	Gross Earnings

I hereby declare that the information given is true and correct.

Date: 

Y	Y	Y	Y

M	M

D	D

Employer's Signature.....

**SECTION 5 : TO BE COMPLETED  
For Employment Injury Only**

**Declaration of Claimant**

Did the accident occur while you were on the job?  YES  NO

State date and time the accident occurred. 

Y	Y	Y	Y

M	M

D	D

 A.M  P.M

At the time of the accident were you engaged in activities required by your duties?  YES  NO

Exact place/location where the accident occurred .....

How did the accident occur?.....

.....

.....

What injuries were sustained? .....

.....

Give the name of any witness to the accident.....

**I hereby declare that the information given is true and correct.**

Claimant's Signature.....

**Declaration of Employer**

Was the claimant required to be in the area where the incident occurred for the purpose of his/her work?.....

What are the claimant's normal hours of work?.....

What is the nature of the claimant's job?.....

Was the injury reported to his/her supervisor at the time it occurred?.....

**I hereby declare that the information given is true and correct.**

*EMPLOYER'S STAMP HERE*

Employer's Signature .....

**Warning: Any person who knowingly makes a false statement or representation for the purpose of obtaining a benefit commits a criminal offense punishable by fine or imprisonment or both.**