SIND EMPLOYEE S' SOCIAL SECURITY INSTITUTION

Employer's Report of a Serious Accident to the Social Security Institution

To be sent to the nearest Local Office of the Social Security Institution within 24 hrs. after the occurance of each serious accident)

Name of Firm _____

Aderess _____ Employer's Registration Number | | | |

Telephone number _____

PART I. This is to certify that at _____ a.m./p.m. on the _____ day of _____ 197 name of employee) _____ _____ of (address) _____ _____whose registration number is | | | | | | | | suffered a serious employment injury as follows _____

_____

(give brief description of nature and extent of injury)

_____ _____ _____

PART II. The circumstances of the accident were _____ _____

_____

(give brief description of how the accident occured)

PART III. Employer's observations _____

I Certify that the above statements are true to the best of my knowledge and belief and I assume full reponsibility as to their correctness.

Signature _____ _____

Date _____ _____ 19. ____ Designation _____

Form B. 3.

Stamp of firm.