Form No. S.F. 1

A.P. Ltd. Kingston, Jamaica.

STANDARD FORM FOR
EMPLOYER'S FIRST REPORT OF INJURY

Approved by I.A.I.A.B.C.

State's Number For:	File: Carrier: Employer:
Carrier's File No.	
(The spaces above not to be filled in by Employer)	

Employer

1. Name of Employer
2. Office Address: No. and St. City or Town State
3. (a) Are you insured to provide payment to injured employees under the Workmen's Compensation Act
   (b) If so insured, give name of insurance company (not name of agent)
4. Give nature of business (or article manufactured)

Time and Place

5. (a) Location of plant or place where accident occurred
   Department State if employer's premises
   (b) If injured in a mine, did accident occur on surface, underground, shaft, drift or mill
6. Date of Injury 19 Day of week Hour of day A.M. P.M.
7. Date disability began 19 A.M. P.M. 8. Was injured paid in full for this day
9. When did you or foreman first know of injury
10. Name of foreman

Injured Person

11. Name of Injured (First Name) (Middle Initial) (Last Name) (Social Sec. No.)
12. Address: No. and St. City or Town State
13. Check (√) Married, Single, Widowed, Widower, Divorced; Male, Female
14. Speak English
15. Age Did you have on file employment certificate or permit
16. (a) Occupation when injured (b) Was this his or her regular occupation
    (If not, state in what department or branch of work regularly employed)
17. (a) How long employed by you (b) Piece or time worker (c) Wages per hour $
18. (a) No. hours worked per day (b) Wages per day $
    (c) No. days worked per week (d) Average weekly earnings $
    (e) If board, lodging, fuel or other advantages were furnished in addition to wages, give estimated value per day, week or month

Cause of Injury

19. Machine, tool or thing causing injury 20. Kind of power (hand, foot, electrical, steam, etc.) 21. Part of machine on which accident occurred
22. (a) Was safety appliance or regulation provided (b) Was it in use at time
23. Was accident caused by injured's failure to use or observe safety appliance or regulation
24. Describe fully how accident occurred, and state what employee was doing when injured
25. Names and addresses of witnesses

Nature of Injury

26. Nature and location of injury (describe fully exact location of amputations or fractures, right or left)
27. Probable length of disability 28. Has injured returned to work
    If so, date and hour at what wage $ At what occupation
29. Did you provide medical attention
30. (a) Name and address of physician
    (b) Name and address of hospital

Fatal Cases

31. Has injured died If so, give date of death

Date of this report Firm Name

Signed by Official Title