Rijksdienst Caribisch Nederland
RCN-Unit Sociale Zaken en Werkgelegenheid

A. Notification form industrial accident

To be filled in by the employer

OMF no.: [ ]
(To be filled in by SZW)

About the employee		
Surname		
Given names		
Date of birth		
ID number		
Position		
Telephone number		
About the company		
Trade name		
Sector		
Business address		
Name employer		
About the position		
How many hours a week does the affected employee work?		
What is the gross salary?	Per week $	
	Per month $	Per hour $

Please note: The form continues overleaf

About the accident	
Date and time of the accident	[- -]Date [:] Time
Where did the accident take place?	o At work o On the way between work and home (demonstrably the shortest route)
How did the accident take place? Provide an accurate description so that a good picture of the event can be obtained.	
Is there potentially question of permanent physical injury?	0 Yes 0 No

Date: - -

Place:

Signature employer:

Rijksdienst Caribisch Nederland
RCN-Unit Sociale Zaken en Werkgelegenheid

B. Notification form industrial accident

To be filled in by the medical professional administering the first aid

Your name	
On what date and at what time was the treatment administered?	
Is the treatment continued and if yes, by whom?	
Can the affected person independently stay at home, will he be nursed at home or is he hospitalised?	
What body part was affected and what is the nature of the bodily harm? Or: What is the nature of the (occupational) disease?	
Further communications that may be relevant to the control physician for the assessment of the accident (e.g. in connection with declared previously existing disorder, etc.) *Please add the documents that may be relevant, e.g. a copy of the discharge letter.*	
Did the bodily harm / the occupational disease give, from a medical perspective, cause to discontinue the work?	Unfit for work from:

Date: - -

Place:

Signature medical professional: