TVK

NOTICE OF OCCUPATIONAL ACCIDENT

Based on the Workers' Compensation Act effected on 1 January2016

1. INFORMATION ABOUT THE EMPLOYER

Name of the employer (The official name of the company)

Street address	**Postal code**	**Postal district**
Telephone	**Business ID (Y-tunnus)**	
Field of operations	**Insurance number**	
International bank account number (IBAN)	**Unit or departmental code of the company**	

2. INFORMATION ABOUT THE INJURED PERSON

Family name and given names		**Personal identity number**	
Street address	**Postal code**	**Postal district**	**Language** ☐Fin ☐Eng
Telephone	**E-mail**		
Occupation	**International bank account number (IBAN)**		

Does the injured person own a share of the company? ☐no ☐yes

Position in the company

Percentage of shares and voting rights, held both personally and jointly with family members

Permanent workplace: Municipality or address	**Nationality**

3. INFORMATION ABOUT THE ACCIDENT

Date of the accident:	**Weekday**	**Time:**
Accident occured in (municipality and address)	**On the date of the accident, work should have** started at ended at	

4. CIRCUMSTANCES OF THE ACCIDENT

Did the accident take place: (Choose one option (1–6) and answer to the related question, if any)

☐1. At work, in connection with work

☐2. At work, during work-related travel

☐3. In the working area, but not during working processes. If yes, describe the working area:

- ☐3a. Working area required by the working process (e.g. permanent workplace, client's premises, meeting room)
- ☐3b. Employee's home
- ☐3c. Other than the premises provided by the employer (such as a cafe)

☐4. Commuting between home and work

☐5. During a meal or recreational break outside the working area. If yes, also describe the working area:

- ☐5a. Working area required by the working process (e.g. permanent workplace, client's premises, meeting room)
- ☐5b. Employee's home
- ☐5c. Other than the premises provided by the employer (such as a cafe)

☐6. In the course of activities other than those detailed above. If yes, where:

- ☐6a. At a training event
- ☐6b. In the course of activities provided by the employer to maintain the ability to work
- ☐6c. At a recreational event
- ☐6d. In the course of travel related to the above activities
- ☐6e. During a health care appointment
- ☐6f. In other activities, please specify:

5. HOW THE ACCIDENT OCCURRED

What kind of work was the employee performing? How did the situation develop? How did the accident occur?
If the accident took place in the course of travel, please describe:

- the destination, route and method of travel (e.g. on foot, by car)
- how the accident occurred

DATA COLLECTED FOR THE PREVENTION OF ACCIDENTS

Only complete if the accident took place at work or in the working area, but not in the course of the working process.

Enter the occupational accident codes in the boxes below

For further information, please consult the instructions for completing this form

Working environment (A):	Working process (B)	Specific physical activity (C):	Deviation (D):	Contact and mode of injury (E):	Agent (F):

6. FURTHER INFORMATION ABOUT THE ACCIDENT

Did the injured person stop working after the accident?
☐no ☐yes ☐later (date and time):

Medical treatment began (date):

Name and address / Location of the first treatment provider

Will the accident cause inability to work (as estimated by the person competing this form)?
☐no ☐yes; duration: ☐date of the accident ☐1-2 d ☐ at least 3 d

Date when the employer was informed of the accident

Company's occupational health care provider (name and address)

Type of injury, e.g. fracture, contusion, burn, sprain (as estimated by the person completing this form)

Part of body injured (e.g. eye, back, fingers, lower extremities)
☐right ☐left

Is this a road accident? ☐no ☐yes

Has the police been informed? ☐no ☐yes, name of the police department:

Did any of the following factors have an effect on the accident? (Please choose the factor(s) and describe the effect)

☐alcohol or narcotics
☐abuse of medication
☐conduct in violation of occupational safety
☐gross negligence / criminal offence

How did this factor have an effect on the accident?

7. INFORMATION ABOUT THE EMPLOYMENT CONTRACT

Please only complete if inability to work continues for 3 days or more

☐**Employment contract of unlimited duration**
Date when the contract began:

☐**Employment contract of limited duration**
Duration of contract:

☐**Main occupation** ☐**Second occupation**

Working hours per week

If part-time work: length of the working day, the number of working days per week and the reason for part-time work

Who can provide information on the employment contract and pay (e.g. payroll manager, name, telephone, e-mail)?

Has the injured person been working for other employers at the same time?
☐no ☐yes, name and contact details of the employer:

Has the injured person been self-employed at the same time?
☐no ☐yes; ☐farming ☐other self-employment

Is the injured person
☐student; enter the name of school:
☐retired; enter the type of pension and date of retirement:

8. INFORMATION ABOUT EARNINGS

Please only complete if inability to work continues for 3 days or more

SALARIES AND WAGES: Pay in money for a period of 4 weeks preceding the accident or if the period of employment was shorter than 4 weeks, for the entire period (excluding the date of accident). Please only enter pay in money, without fringe benefits and holiday pay.

Withholding rates (from the tax card)
Basic rate Additional rate Basic rate income ceiling (per year)

Does the injured person receive sick pay?
☐**1. yes** (fill options 1a-1d) ☐**2. no** (fill options 2a-2d) ☐Information about the amount of sick pay is given later

1a. Received sick pay for the period of **euro**

1b. Statutory sick pay ends (date)

1c. Has the injured person received sick pay for the entire period of inability to work or for a part of it, e.g. due to a lay-off or partial pension?
☐For the whole disability period ☐ Only partially, fill options 2a-2d

1d. Has only part of the salary paid as illness pay? (e.g. 50% of salary in case the employment has lasted less than a month)?
☐yes; filloptions 2a-2d ☐no

If no sick pay has been paid or you selected 1c. or 1d, please complete the information about pay.

2a. pay for the period of **euro**

2b. Basis of pay calculation, euros per hour

2c. Unpaid absences during this period, with dates and causes

2d. Monthly pay	Pay at the time of the accident, euros per month	Any allowances, the type of allowance and the average amount, euros per month

9. SIGNATURE

Contact details of the person who can provide further information on the accident (name, telephone, e-mail)

Place and date

Telephone and e-mail of the employer / employer's representative

Clear Form