

**Social Welfare Services Office,
Recovery of Benefits and
Assistance Section,
P.O. Box 12515,
Dublin 1,
D01 WY03.**

Y	Y	Y	Y
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Details of Injured Person	
1. Name of Injured Person	
2. Age	
3. Sex	
4. Address	
5. Telephone	
6. Occupation	
7. Date of Birth	
8. Date of Injury	
9. Date of Report	
10. Date of Examination	
11. Date of Discharge	
12. Date of Follow-up	
13. Date of Final Report	
14. Date of Final Examination	
15. Date of Final Discharge	
16. Date of Final Follow-up	
17. Date of Final Report	
18. Date of Final Examination	
19. Date of Final Discharge	
20. Date of Final Follow-up	

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***Mandatory**

[illegible][illegible]

○ Female: ○

[illegible]

D	D	/	M	M	/	Y	Y	Y	Y	Date of death (if applicable)	D	D	/	M	M	/	Y	Y	Y	Y
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[illegible][illegible]

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***Are details of the Injured Person's agent/personal representative known? Please tick: Yes ☐ No ☐**
If 'Yes' it is mandatory to enter the details below

[illegible][illegible][illegible][illegible]

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[illegible][illegible][illegible][illegible]

D	D	/	M	M	/	Y	Y	Y	Y
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: hrs

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Note: Please specify the injury/illness suffered by the injured person, e.g. broken left leg, arm fracture. Do not describe injuries as soft tissue injury, post op, in RTA, medical negligence, etc.

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RBA01 (09-2017)