Should you require any assistance in completing this form, you can contact PIAB Helpline
8am – 8pm Monday to Friday
on Lo-Call **1890 829121**

Form A

piab
Bord Measúnaithe Díobhálacha Pearsanta
Personal Injuries Assessment Board

Application for Assessment of Damages under Section 11 of the Personal Injuries Assessment Board Act 2003

PLEASE COMPLETE IN BLOCK CAPITALS

Type of Accident - Please Tick:

Motor ☐ At Work ☐ Other ☐

Claimant Details

Application No. (Input by PIAB)					
Name:					
Home Address:					
Telephone:		Mobile:			
Gender:	Male		Female		
Date of Birth: (dd/mm/yyyy)					
Occupation: Employee Number (if known)					

THE RESPONDENT IS THE PERSON OR COMPANY YOU ARE MAKING THE CLAIM AGAINST AND ARE HOLDING RESPONSIBLE FOR THE INJURY/ACCIDENT.IF THERE ARE MORE THAN THREE RESPONDENTS, PLEASE ADD ON A SEPARATE SHEET.

RESPONDENT Number 1

Name:					
Address:					
Relationship to Claimant (*e.g. Employer)*					
Contact Name *(if known)*		Phone:			
If this is a Motor claim please provide the following additional details *(if known)*					
Registration Number of the Respondent's vehicle:		Make		Model	
Respondent Insurance Company					
Respondent Insurance Policy Number / Claim Number					

RESPONDENT Number 2

Name:					
Address:					
Relationship to Claimant (*e.g. Employer)*					
Contact Name *(if known)*		Phone:			
If this is a Motor claim please provide the following additional details *(if known)*					
Registration Number of the Respondent's vehicle:		Make		Model	
Respondent Insurance Company					
Respondent Insurance Policy Number / Claim Number					

RESPONDENT Number 3

Name:					
Address:					
Relationship to Claimant (*e.g. Employer)*					
Contact Name *(if known)*		Phone:			
If this is a Motor claim please provide the following additional details *(if known)*					
Registration Number of the Respondent's vehicle:		Make		Model	
Respondent Insurance Company					
Respondent Insurance Policy Number / Claim Number					

Accident Details

Date of injury / accident (dd/mm/yyyy)		Time of injury / accident	
Where did the injury / accident occur? (please detail the exact location where possible)			
Brief description of how the accident occurred:			

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Injury/Claim Details

Brief details of the injury:	
On what date did you first seek medical attention?	
From whom did you first seek medical attention?	
Name & address of current medical attendant if different from above.	

You are required to submit a medical report from your treating doctor with your application. Are you satisfied that the medical report you are attaching adequately describes your injury? Yes ☐ No ☐

If "No", please provide further information in the box below

Previous relevant injuries/conditions/accidents

Have you suffered any other injury or from any relevant medical condition or been involved in any other accident in the past 5 years, whether or not resulting in a claim for compensation, which is relevant to your current claim? Yes ☐ No ☐
If "Yes", please provide full details

Special Damages e.g. Loss of wages, medical expenses, out of pocket expenses.

Are you claiming for loss of wages? If "Yes" please state the dates that you were absent from work due to injury.	Yes ☐		No ☐	
	From:		To:	
State the amount that you are claiming for loss of wages (based on net earnings) if known at present	€			
If you are still medically certified as unfit, when is it expected that you will return to work?				
Are you claiming for medical expenses? If "Yes", attach receipts and state the amount.	Yes ☐ €		No ☐	
Are further medical expenses expected? If so, please furnish details	Yes ☐		No ☐	
Are you claiming any other loss or expense? If "Yes", please detail and state the amount	Yes ☐		No ☐	
Is other loss or expense expected? If "Yes", please detail and estimate amount involved	Yes ☐		No ☐	

It is important to note that you will have an opportunity to update and detail your final claim for special damages before any assessment is made

I hereby declare that the above information is, to the best of my knowledge, true and accurate in every respect

Signature of Claimant: _____

Date: _____

Please note, the Respondent/s named by you and their insurers where known will be copied with your application form and medical report in order that they may know the nature and extent of your claim. The Respondent and their insurers are required to treat such information confidentially and not to further disclose it.

Completed Application and necessary documentation should be returned to:
Personal Injuries Assessment Board, P.O. Box 8, Clonakilty, Co. Cork