WORKERS' COMPENSATION FUND CONTROL BOARD

EMPLOYER FORM

EMPLOYER MAIN DETAILS

1. **EMPLOYER NAME:**
2. **POSTAL ADDRESS:**
3. **EMAIL ADDRESS:**
4. **TELEPHONE NO.:** **5. FAX NO.:**
6. **EMPLOYER NO:** **7. BRANCH CODE:**
8. **PACRA NO:**
9. **TPIN NO:**

EMPLOYER'S PHISICAL ADDRESS

10. **PLOT NO.:** **11. STREET NO/NAME:**
12. **BUILDING NAME:**
13. **FLOOR NO.:** **14. OFFICE NO.:**
15. **TOWN NAME:** **16. PROVINCE NAME:**

CONTACT PERSON DETAILS

17. **NAME:** **18. PHONE NO.:**
19. **DESIGNATION:** **20. FAX NO.:**

BUSINESS STATUS

21. **CLASS CODE:**
22. **BUSINES/WORK TYPE:**
23. **LICENCE TYPE:**
24. **REGISTRATION DATE:**
25. **DATE BUSINESS COMMENCED:**
26. **DATE CLOSED:**
27. **DATE SUSPENDED:**

COMPANY

DATE STAMP

SIGNATURE:..... DATE:.....

NAME (PRINT):..... POSITION:.....