CD-1181-0826

State of New Jersey • Department of the Treasury

PFRSNJ DISABILITY RETIREMENTS

P.O. Box 297, Trenton, NJ 08625-0297

EMPLOYER CERTIFICATION — ACCIDENTAL DEATH ON DUTY

PART 1 — DECEASED PFRSNJ EMPLOYEE INFORMATION

Name of Deceased Member _____

Position Held At Time of Death _____ Membership Number _____

Name of Employer _____ County _____

Employer ID _____

PART 2 — ACCIDENT INFORMATION

Time and date of fatal accident _____ am/pm _____/_____/_____
Time *Date*

Exact place of accident _____
Street *City* *State* *County*

Was employee hospitalized after accident? ☐ Yes ☐ No If so, name and address of hospital and inclusive dates of hospitalization _____

Time and date of death _____ *am/pm* _____/_____/_____
Time *Date*

Detailed description of the fatal accident (attach additional pages if necessary) _____

_____

Names and addresses of any witnesses to the accident _____

_____

_____

PART 3 — EMPLOYER RECORDS

Do employer records acknowledge and describe the accident? ☐ Yes ☐ No

When was employer's record of the accident made? _____/_____/_____
Date

Has the employer made an official determination that the member died as a result of an accident arising out of and in the course of employment which was not the result of willful negligence? ☐ Yes ☐ No If yes, please attach a copy of the official proceedings and the final determination.

Was the employee performing regular assigned duties at the time of the accident? ☐ Yes ☐ No

The specific duties assigned the employee at the time of the accident _____

_____

Employee's immediate supervisor at time of accident _____
Name *Title*

Was an autopsy performed to show cause of death? ☐ Yes ☐ No

PART 4 — SIGNATURE

I hereby certify the information shown above is true and correct to the best of my knowledge and belief.

_____ _____
Print Certifying Officer Name *Phone Number*

_____ _____/_____/_____
Signature of Certifying Officer *Date*