MASSACHUSETTS EDUCATION & GOVERNMENT ASSOCIATION
SPECIALIZING IN WORKERS' COMPENSATION INSURANCE

USE BLACK PEN ONLY **FIRST REPORT OF INJURY**

Fax to: 781-246-3425

☐ **MEDICAL ONLY**- employee has sought medical treatment but has less than 5 days lost time.
☐ **LOST TIME**- employee is out of work for 5 or more days
☐ **REPORT ONLY-** employee has NOT sought medical treatment

*Employer: _____ Please do not abbreviate

*Location/Address: _____
Address where the injured employee works: (Ex. School Name & Address, DPW Address, Town/ City Address)

*Employee's Name _____ DOB: _____

*Employee's. Address: _____

*City _____ State _____ *Zip _____

Phone #: _____ *Social Security #: _____

*Department: _____ *Job Title: _____ *Date of Hire: ____/____/_____

Rate of Pay: _____ *Date of Incident: _____/_____/_____ Time _____

*Body Part: _____ *Type of Injury (strain, laceration, etc.) _____

*Describe what happened: _____

_____

_____

Name of Witness (es) _____

To who was accident/incident reported to? _____ Date Reported _____

*Was medical attention sought? Yes ___ No ____ If yes, *Where? _____

*Did employee return to work? Yes___ No___ If yes, *Date employee returned to work ___/___/_____

*LOST TIME: Please provide the first day out of work because of injury _____/_____/ 20_____

*LOST TIME: Please provide the fifth day out of work because of injury _____/_____/ 20_____

Information Release

I hereby authorize Massachusetts Education and Government Association Property & Casualty Group, Inc. (MEGA), or any of its representatives to be furnished any information and facts regarding medical services rendered to me by any medical provider, including reports/records, results of diagnosis, treatment and prognosis, estimates of disability and recommendations for further treatment. This information is to be used for the purpose of evaluating and handling my claim for injury as a result of an incident occurring on or about the above indicated date of injury and for no other purpose, now or in the future.

Employee Signature: _____ Date: _____

Supervisor/Person filing out form Comments: _____

Supervisor/Person filing out form Signature: _____ Date: _____

*Required

c/o CCMSI 55 Walkers Brook Drive, Suite 402, Reading, MA 01867
PH: (781) 683-1000, Fax: (781)246-3425
www.megawcgroup.com

Town of North Attleborough
Human Resources Department
North Attleborough Public Schools & Town Government

SUPERVISOR'S INCIDENT/ACCIDENT INVESTIGATION REPORT

This form must be completed and sent to the Human Resources Department within 24 hours after an accident

Part 1 - General Information
Scheduled Work Hours: _____ **Date of Report:** _____

Employee: _____ **Dept/School:** _____

Date of Accident: _____ **Hour:** _____ **AM**__ **PM**__ **Exact Location:**_____

Job or Activity at Time of Accident: _____

_____

_____

Part 2 – Description of Accident

_____

_____

_____

_____

_____

Part 3 – What Caused the Accident?

Describe unsafe acts and/or conditions:

_____

_____

Did equipment malfunction? Yes ___ **No** ___ **If yes, describe** _____

Describe damage of equipment or property_____

Part IV – Corrective Actions

What action has been taken or will be taken to correct the unsafe act and/or unsafe conditions to prevent any future recurrence?

_____

_____

_____

Part V – Remarks/Recommendations or orders

_____

_____

_____

_____

Signed: _____
(Supervisor)

Town of North Attleborough
Human Resources Department
North Attleborough Public Schools & Town Government

WORKER'S COMPENSATION REFUSAL OF MEDICAL TREATMENT OF OBSERVATION

Employee's Name: _____

Department: _____

Date of Injury: _____

I, hereby acknowledge my refusal of medical treatment and/or observation offered to me at the expense of the Town of North Attleboro for the work-related injury. By signing this form, I realize that I do not necessarily affect my later eligibility for Workers' Compensation.

I acknowledge that my supervisor(s), in good faith, have offered and made available to me an opportunity to seek necessary medical treatment and/or observation. I am aware that by declining medical treatment at this time, that my employer, will not be responsible for any medical expenses or lost wages.

At a later time, I may request from by employer, via my supervisor, a medical authorization to obtain medical treatment and/or observation for the above-described injury.

Employee's Signature Date

Employee Representative/Witness Date

Town of North Attleborough
Human Resources Department
North Attleborough Public Schools & Town Government

MEDICAL RELEASE AUTHORIZATION

Today's date: _____

Employee: _____

Department: _____

Date of injury: _____

This also applies to any other physicians, hospitals, clinics, or other medical providers presently unknown to me, who may have or subsequently acquire information concerning my medical condition due to this injury.

You are hereby authorized to provide to MEGA, or any of its representatives, all information, facts, particulars, including reports, records, results from diagnostic tests, x-rays or other images, and statements of charges which may be requested regarding my medical condition, diagnosis, treatment and the rendered, prognosis, estimates of disability, or recommendations for further treatment and to furnish them copies of such information. You are further authorized to allow any physician appointed by them to review all such reports, records, x-rays, or other images in your possession.

I agree that a photostatic or electronic copy of this authorization be accepted with the same authority as the original.

This medical release authorization is for medical information related to this injury only. This authorization expires at the conclusion of this claim.

Employee Signature:_____Date: _____