FIRST REPORT OF INJURY

Fax to: 781-246-3425 **(* Represents required fields in red)**

☐ ***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:* ____
Name of Department or Location (Ex. School Name & Address, DPW Location, Town/City Address)

***Employee's Name**____ **DOB:** ____________________

Emp. Address: City** ______________________________________ **State**_______Zip**____________

Home Phone #:_______________________ ***Social Security #:**_______________________________

***Department:** ___________________ ***Job Title:** _____________________ ***DOH:** _______________

Rate of Pay: _______________ ***Date of Incident:** _____/______/________ Time ____________

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

***Describe what happened:** ____

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____

Name of Witness (es) ____

To who was accident/incident reported to? _____________________Date Reported__________

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

***Did employee RTW? Yes___ No___ If yes, *Date employee RTW**_________________________

***LOST TIME: FIRST Date out of work**________________ **FIFTH Date out of work**______________

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/Submitter Comments: ____

Supervisor/Submitter Signature: _____________________________ Date: ____________________

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