MEGA
MASSACHUSETTS EDUCATION & GOVERNMENT ASSOCIATION

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: Town of Edgartown, MA 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:** _____

_____

_____

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: _____

Fax to: 781-246-3425