MIIA Member Services
One Federal Street, Boston Massachusetts 02110
Tel: 888-266-6442 Fax: 617 753-9987

TOWN OF WAREHAM

NAME OF SCHOOL: ____

SUPERVISOR'S REPORT OF ACCIDENT- INTAKE FORM

EMPLOYEE NAME_______________________ SOCIAL SECURITY #_______________
EMPLOYEE ADDRESS____
TELEPHONE #: HOME______________________WORK________________________
MARITAL STATUS___________________ NUMBER OF DEPENDENTS __________
DEPT_________________OCCUPATION_________________HIRE DATE __________
DATE OF BIRTH__________ SEX (M or F)_____AVERAGE WEEKLY WAGE__________
DATE OF INJURY________________________ TIME: ________________________
DESCRIPTION OF INJURY____
LOCATION ACCIDENT OCCURRED____
TO WHOM WAS INJURY REPORTED ____
THEIR POSITION____________________ DATE & TIME REPORTED: ____________________
DID EMPLOYEE LOSE TIME FROM WORK ____ Y ______ N
IF YES, 1ST DISABILITY DATE______________RETURN TO WORK DATE____________
WAS MEDICAL TREATMENT SOUGHT ____ Y _____ N
WITNESSES____
THEIR POSITION(S)____

*******Supervisor's Complete Below*********

DESCRIPTION OF ACCIDENT; WHAT WAS EMPLOYEE DOING? WHAT HAPPENED? WHY?

CAUSE-UNSAFE ACT OR CONDITION; OBJECT/SUBSTANCE CAUSING INJURY

WAS EMPLOYEE WEARING SAFETY GEAR? YES_______NO_____(IF NO, EXPLAIN)

ACTION TAKEN TO PREVENT SIMILAR ACCIDENTS

REMARKS

Investigated By___________________________________Date_______________________

Reviewed By_____________________________________Date_______________________

______ School Nurse ______ Supervisor _____ Teacher's Retirement

Massachusetts

MIIA

Interlocal Insurance Association
MIIA Member Services
One Federal Street, Boston Massachusetts 02110
Tel: 888-266-6442 Fax: 617 753-9987

MEDICAL AUTHORIZATION

To: ________________________________ Date:_____________________

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and any other physician, hospital, clinic or medical care provider, presently unknown to me, who may have or subsequently acquire information concerning my physical condition. You are hereby authorized to give Aon Risk Services of Massachusetts and the CorVel Corporation (or any of its representatives), all information, facts and particulars, including reports, records, results from diagnostic tests, X-rays and statements of charges which may be requested regarding my medical condition, diagnosis, treatment and to furnish them copies of such reports. You are further authorized to allow any physicians appointed by them to review all such reports, records and X-rays in your possession.

I am willing that a photostatic copy of this authorization be accepted with the same authority as the original.

This information is to be used for handling my claim from an occupational injury or illness occurring on or about ____________________________ and for no other purpose, now or in the future.

This authorization is valid for the duration of the above condition.

____ ____________________________
(Employee's signature) (Date)

Employer: **TOWN OF WAREHAM**

Name of Employee:______________________________________

SS#: ____________________ Date of Birth: ______________________

Claim #:____________________ Date of Accident: ______________________

Massachusetts
MIIA
Interlocal Insurance
Association

An Interlocal Service of the Massachusetts
Municipal Association
Member Services
One Federal Street, Boston Massachusetts 02110
Toll Free (Mass): 888/266-6442
Fax: 617 753-9987

WITNESS STATEMENT

INJURED EMPLOYEE NAME: ____

DEPARTMENT: ______________________________ OCCUPATION: _______________________

LOCATION ACCIDENT OCCURRED: ____

Briefly Describe How Injury Occurred:

Body Part(s) Involved:

Witness Signature: **____** ***Date:*** **__________________**

Witness name (printed): **____**

Witness occupation: ____