



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
- (* Represents required fields in red)

***Employer:** _____
Please do not abbreviate employer name

***Employee's Name** _____ **DOB:** _____

***Address** _____

***City** _____ ***State** _____ ***Zip Code** _____

Home Phone #: _____ ***Social Security #:** _____

Department: _____ **Job Title:** _____ **DOH:** _____

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

Location _____ ***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 Comments _____ *Fax to: 781-246-3425*

Supervisor Signature: _____ Date: _____