MEDICAL ONLY NOTICE OF INJURY

If employee is disabled for 5 or more days, please complete First Report of Injury – Form 101

Employer: NORTH MIDDLESEX REGIONAL SCHOOL DISTRICT

Employee's Name _____ DOB: _____

Address _____

_____

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 whom was accident/incident reported to? _____Date Reported_____

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

Information Release

I hereby authorize *MIIA Insurance Company* 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 _____

_____

Supervisor Signature _____ Date _____

MIIA MASSACHUSETTS BASED MEMBER DRIVEN

Member Services
53 State Street, Boston Massachusetts 02109
Toll Free (Mass) :888/266-6442
Fax: 617 753-9987

MEDICAL AUTHORIZATION

To: _____ Date:_____

_____

_____

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 MIIA Member Services and/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 photo static 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: North Middlesex Regional School District
Name of Employee:_____
SS#: _____ Date of Birth: _____
Claim #:_____ Date of Accident: _____