Work Related Injury/Accident Report Procedure

** Time Sensitive **

Injuries and Accident Reports ***MUST*** be reported to a Supervisor ***IMMEDIATELY***.

Late reports may result in a fine being imposed.

Employee Completes all Accident Reports as follows: The employee is responsible for completing and returning reports to his/her supervisor.

Employee's Report of Injury: All sections are to be completed by the injured employee. When describing the injury, please note if left, right, arm, leg, etc. Also, sign and date the form.

Medical Release Form: This form is **mandatory** with each report, regardless of whether or not the employee is disabled or will seek medical attention. Employee **MUST** sign on employee signature line.

Sick Leave Form: If the employee wants to receive payment for sick leave until Worker's Compensation claim is accepted for period of disability. Employee needs to sign and check off one of the paragraphs.

The employee must return all completed reports to the Principal or Supervisor *before leaving*, except in emergency situations only. In those cases, as soon as possible.

CITY OF NEW BEDFORD

EMPLOYEE'S REPORT OF INJURY

Name of Injured Employee: _____ Date Of Birth: _____ Phone #: _____

Home Address: _____ City: _____ Zip Code: _____

Soc. Sec. #: _____ Dept/School: _____ Occupation: _____ Date of Hire: _____

Employee Status: ☐ Permanent ☐ Provisional ☐ Seasonal ☐ Other (Please check one status) Start Time of Work: _____ AM PM

Date of Accident: _____ Day of Week: _____ Time: _____

Location Accident Occurred: _____

WHAT WERE YOU DOING AT TIME OF ACCIDENT: _____

_____

DESCRIBE HOW THE ACCIDENT HAPPENED: _____

_____

_____

DESCRIBE THE INJURY/INJURIES YOU SUSTAINED:

_____

_____

WERE THERE ANY WITNESSES ☐YES ☐NO (Please attach witness statements if applicable)

Witness Name: _____ Position: _____

Witness Name: _____ Position: _____

MEDICAL TREATMENT:

☐ No Treatment ☐ First Aid ☐ Employee Health Clinic ☐ Hospital: _____

Treatment provided at _____

Could Accident Have Been Prevented? ☐ Yes ☐ No ☐ Don't Know

Please explain in detail: _____

_____

Employee's Signature: _____ Date reported: _____

City of New Bedford

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____

TO: _____

ADDRESS: _____

_____

I hereby authorize and direct any physician or surgeon who has examined or treated me and any hospital or clinic where I have been examined or treated to give to the City of New Bedford's Workers' Compensation Agent or designee, at 133 William Street, Room 201, New Bedford, MA 02740, any information which may have been acquired in the course of such examination or treatment as a result of a work-related injury sustained on _____. You are respectfully requested to cooperate with the City's Workers' Compensation Agent or designee in supplying them with requested documents and in answering their questions. No other persons should be granted access to my records without proper authorization signed by me.

I further waive all provisions of the law prohibiting disclosure of any records, and authorize and direct you to give said representative any and all information requested.

A photocopy of this authorization shall be acceptable as the **ORIGINAL**. This authorization is valid for any past, present or future requests by the City's Workers' Compensation Agent or designee for such information until expressly revoked by me in writing.

Signed:_____
Employee signature

Home Address:_____

_____

To:_____

_____

From: CITY OF NEW BEDFORD
WORKERS' COMPENSATION AGENT

SUBJECT: _____
Name of Employee

Signed _____
Workers' Compensation Agent

DATE OF ACCIDENT:_____

CLAIM NUMBER: _____

PATIENT ACCOUNT NUMBER:_____

ADDRESS:_____

_____

The City of New Bedford is self-insured for workmens' compensation. The above named employee has a claim pending as a result of a work-related injury incurred during the course of his/her employment on the above-stated date.

The City's policy requires that you furnish us with a copy of your records in this case, or pertinent report, before your bill is approved for payment.

CITY OF NEW BEDFORD

Department _____

injured
Name of/Employee _____

Address _____

PHYSICIAN'S REPORT — INDUSTRIAL ACCIDENT

(YOUR EARLY COOPERATION IS APPRECIATED SINCE THIS FORM IS REQUIRED BEFORE BENEFITS WHICH MAY BE DUE CAN BE PAID.)

History _____

Physical findings _____

Diagnosis _____

Cause of condition or injury _____

Is employee disabled for work? _____

If disabled for work, please estimate disability

days _____ weeks _____

Date _____ _____
Signature of Physician

Tel. _____ _____
Address

REQUEST FOR SICK LEAVE

PLEASE CHECK THE FOLLOWING THAT APPLY:

☐ I hereby apply for sick leave pending approval of my claim for workmen compensation. I understand that this application will not affect the approval or disapproval of my claim. I will reimburse the City for those days of sick leave which are paid to me and are determined to be payable under workman compensation, if my claim is approved.

☐ I hereby apply for use of my sick leave, if my claim is approved, to make up the difference between the workman compensation rate (60% of wages) and my full rate of pay. If I do not choose this option, I realize I will receive workman compensation wages only, if my claim is approved.

_____

SIGNATURE OF EMPLOYEE

IF YOU:

- have filed a claim for workman's compensation and

- you are required by a doctor to be out of work as a result of injury sustained

THEN, if your claim is approved;

-if you are out of work for six or more days, your first five days will be paid to you out of your accumulated sick leave, if any are available.

-the sixth day and each day after will be paid to you from workman's compensation at 60% of your wages.