MIIA MASSACHUSETTS BASED MEMBER DRIVEN
617-753-9987

Town of Chelmsford

SUPERVISOR'S REPORT OF ACCIDENT AND CLAIM INTAKE FORM

EMPLOYEE NAME _____ DATE OF INJURY _____

TIME OF INJURY _____ ACKNOWLEDGE/DATE REPORTED _____

DESCRIPTION OF ACCIDENT [WHAT WAS EMPLOYEE DOING? WHAT HAPPENED?]

CAUSE:_____ INJURY:_____ BODY PART:_____ OCCUPATION_____

SOCIAL SECURITY #_____ SEX _____ MARITAL STATUS _____

DATE OF BIRTH_____ NUMBER OF DEPENDENTS _____ DATE OF HIRE_____

DEPARTMENT_____ SUPERVISOR NAME _____ PHONE _____

EMPLOYEE ADDRESS_____

PHONE: H_____W_____ C_____EMAIL_____

LOCATION OF ACCIDENT _____ INJURED ON PREMISES YES ◯ NO ◯

AVERAGE WEEKLY WAGE _____

DID EMPLOYEE LOSE TIME FROM WORK? YES ◯ NO ◯

DID EMPLOYEE RETURN TO WORK YES ◯ NO ◯ IF YES, DATE RETURN TO WORK:_____

TIME BEGAN WORK_____

IF NO, LAST DAY WORK_____1ST DAY OF DISABILITY_____5TH DAY OF DISABILITY_____

WAS MEDICAL TREATMENT SOUGHT? YES ◯ NO ◯ MEDICAL FACILITY _____

DATE REPORTED AS WORK RELATED _____ WITNESS _____

TO WHOM WAS INJURY REPORTED _____

ROOT CAUSE OF ACCIDENT:

WAS EMPLOYEE WEARING SAFETY GEAR? YES ◯ NO ◯ (IF NO, EXPLAIN BELOW)

ACTION TAKEN TO PREVENT SIMILAR ACCIDENTS:

Investigated By_____ Date_____

Reviewed By_____ Date_____

School Nurse ◯ Supervisor ◯

form date: 8/5/2019