# WAKEFIELD POLICE & FIRE CIVIL SERVICE
# MEDICAL ONLY NOTICE OF INJURY

Employer: **TOWN OF WAKEFIELD**

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? Y or N? If yes, when?

Doctor's Name:

Address:

Has the employee returne to work? If yes, when?

Probable length of injury:

Employee Signature: Date:

Supervisor Comments:

Supervisor Signature: Date:

Dept Head Signature: Date:

Return forms to Benefits Office, Town Hall, 1 Lafayette Street, Wakefield, MA 01880
Ph. (781) 246-6396 | Fx. (781) 246-2400 | Em. aforziati@wakefield.ma.us