MEGA

MASSACHUSETTS EDUCATION & GOVERNMENT ASSOCIATION
PROPERTY AND CASUALTY GROUP, INC.

MEDICAL ONLY NOTICE OF INJURY

To be completed by the Employee

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

Employer: **TOWN OF WAKEFIELD** MEGA Location #: **X34**

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, Where?

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:

Supervisor Signature: Date:

Dept Head Signature: Date:

Town's Workers Comp Rep 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

Accident Investigation Report

To be completed by the supervisor

Part I

Employee's Name: DOB:

Job Title: Dept: Age: Sex:

Date of Accident: Time: Check if time is unknown:

Exact Location of Accident:

Part II

Extent of Injury: (Describe specific body part and how it was affected)

Describe Accident:

Accident Cause(s):

Employee was injured, Y or N: Employee received first aid at work site, Y or N:

Employee was treated in an Emergency Room, Y or N:

Did employee return to work, Y or N? If yes, date: and time:

Accident reported to whom?

Witness(es):

Part III

Corrective Action Plan (What has been done or what has been recommended to prevent a recurrence)

Has it been done, Y or N? If not, give reason:

Completed by: Date:

Supervisor's Signature: Date:

Reviewed & Approved By: Date:

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