



TOWN OF FOXBOROUGH

SUPERVISOR'S REPORT OF ACCIDENT- INTAKE FORM

EMPLOYEE NAME _____ SOCIAL SECURITY # _____

EMPLOYEE ADDRESS _____

TELEPHONE NU: HOME _____ WORK _____

MARITAL STATUS _____ DATE OF HIRE _____

DEPARTMENT _____ OCCUPATION _____

DATE OF BIRTH _____ SEX(M or F) _____ AVERAGE WEEKLY WAGE _____

NUMBER OF DEPENDENTS _____ DATE OF INJURY _____

DESCRIPTION OF INJURY _____

LOCATION ACCIDENT OCCURRED _____

WITNESS _____ WITNESS ADDRESS _____

TELEPHONE NU: _____

TO WHOM WAS INJURY REPORTED TO/THEIR POSITION _____

DID EMPLOYEE LOSE TIME FROM WORK? (Y or N) _____

FIRST DAY OF DISABILITY _____ FIFTH DAY OF DISABILITY _____

WAS MEDICAL TREATMENT SOUGHT?(Y or N) _____ Tax ID Number: _____

MEDICAL FACILITY _____

DATE REPORTED A WORK RELATED: _____ INJURY: _____ BODY PART: _____

RETURN TO WORK DATE: _____

*****Supervisor's Complete Below*****

DESCRIPTION OF ACCIDENT; WHAT WAS EMPLOYEE DOING? WHAT HAPPENED?WHY? _____

CAUSE-UNSAFE ACT OR CONDITION; OBJECT/SUBSTANCE CAUSING INJURY _____

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

ACTION TAKEN TO PREVENT SIMILAR ACCIDENTS _____
REMARKS _____

Investigated By _____ Date _____

Reviewed By _____ Date _____

School Nurse

Supervisor



Member Services
One Federal Street, Boston Massachusetts 02110
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 photostatic 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: TOWN OF FOXBOROUGH _____

Name of Employee: _____

SS#: _____ Date of Birth: _____

Claim #: _____ Date of Accident: _____