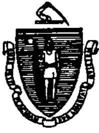
FORM 101



The Commonwealth of Massachusetts
Department of Industrial Accidents - Department 101
1 Congress Street — Ste 100 , Boston, MA 02114 - 2017
Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470
http://www.state.ma.us/dia

DIA USE ONLY

# EMPLOYER'S FIRST REPORT OF INJURY OR FATALITY

**THIS FORM MUST BE FILED BY THE *EMPLOYER* IN THE EVENT OF AN INJURY THAT RESULTS IN DEATH OR FIVE OR MORE CALENDAR DAYS OF TOTAL OR PARTIAL INCAPACITY FROM EARNING WAGES.**
***INSTRUCTIONS AND CODES ON THE REVERSE SIDE*** **- Please Print Legibly or Type - Unreadable forms will be returned.**

**EMPLOYEE**

| | | | |
|---|---|---|---|
| 1. Employee's Name (Last, First, MI): | 2. Home Telephone Number: | 3. Social Security Number*: | 4. Sex: |
| 5. Home Address (No., Street, City, State & Zip Code): ' '' | | 6. Marital Status: | 7. No. of Dependents: |
| 8. Date of Hire (mm/dd/yyyy): | 9. Date of Birth (mm/dd/yyyy): | 10. Average Weekly Wage: $ ☐ Estimated ☐ Actual | |

**EMPLOYER**

| | |
|---|---|
| 11. Employer's Name: | 12. Federal Tax I.D. Number: |
| 13. Employer's Address (No., Street, City, State & Zip Code): '' ' ' | 14. Employer's Telephone Number: |
| | 15. Industry Code (See Reverse Side): |
| 16. Workers' Compensation Insurance Carrier and Tel. No. (NOT LOCAL AGENT/ADMINISTRATOR): MIIA c/o Aon Risk Solutions One Federal Street, Boston, MA 02110 1-888-266-6442 | 17. W.C. Policy Number: |
| 18. Self-Insured? ☐ Yes ☒ No<br>If Yes, Self-Insurer Number | 19. Business Type: ☒ Service ☐ Wholesale ☐ Mfg. ☐ Retail ☐ Other |

**INJURY INFORMATION**

| | | |
|---|---|---|
| **20. DATE OF INJURY** | **20a. Insurer's Case/Claim File No.:** | |
| 21. Was Employee Injured on Employer's Premises? ☐ Yes ☐ No | 22. Location of Injury if not on Employer's Premises: | |
| **23. FIRST day of Total or Partial Incapacity to Earn Wages :** | **24. FIFTH day of Total or Partial Incapacity to Earn Wages** | |
| **25. If Employee has Died, Date of Death (mm/dd/yyyy):** | 26. Source of Injury (Chemicals, Machinery, etc.): | |
| 27. Briefly Describe How Injury/Exposure Occurred and Body Parts(s) involved: | | |
| 28. Person to Whom Injury was Reported (list position): | 29. Date Reported | 30. Date reported as work related |
| 31. Injury Code(s) Body Part Code(s)<br>a. to body part a.<br>b. to body part b.<br>c. to body part c. | 32. Witness(es) to Injury - Give Full Name(s), if none state as such: ' ' | |
| 33. Has Employee Returned to Work ☐ Yes ☐ No | 34. Date Employee Returned to Work (mm/dd/yyyy): | |
| 35. Employee's Regular Occupation: | 36. Has Employee Returned to Regular Occupation: ☐ Yes ☐ No | |
| 37. EMPLOYER'S Name (SEE INSTRUCTIONS ON REVERSE SIDE): | 38. Title: | |
| 39. EMPLOYER'S Signature (SEE INSTRUCTIONS ON REVERSE SIDE): **Signature on File** | 40. Date Prepared (mm/dd/yyyy): | 40a. PREPARER'S e-mail address |

*Disclosure of Social Security Number is Voluntary. It will aid in the processing of your report.



**THIS FORM DOES NOT CONSTITUTE AN EMPLOYEE'S CLAIM FOR BENEFITS UNDER WORKERS' COMPENSATION.**