CITY OF MARLBOROUGH & MARLBOROUGH PUBLIC SCHOOLS

CLAIMANT'S FORM
NOTICE OF EMPLOYEE ACCIDENT

This form must be submitted to the Human Resources Dept. within 24 hours after an accident.

Please Print or Type - Please be as complete as possible

Today's Date:_____

INJURED PERSON

Name of Injured: _____ SS#: _____
(First Name) (MI) (Last Name)

Address: _____ City/Town: _____ State: _____ Zip: _____

Sex: Male: ☐ Female: ☐ Marital Status: Married: ☐ Single: ☐ Widowed: ☐ Divorced ☐

Date of Birth: _____ Phone Number: _____

Occupation (title) when injured: _____ Was this your regular occupation? Yes ☐ No ☐

(If not, state in what department or branch of work are regularly employed): _____

How long employed: _____ Number hours worked per day _____ Number days worked per week: _____

Wages per day $_____ Average weekly earnings $_____

TIME AND PLACE

Date of Injury: _____ Time of Injury: _____

Where did the injury occur (address/building)? _____

Did this injury occur on or off the employer's premises? Yes ☐ No ☐

Was the injured paid in full for this day? Yes ☐ No ☐ When was injury reported (date): _____

To Whom was the Injury reported to (name and title): _____

CAUSE OF INJURY

Machine, Tool, or Something Else Causing Injury: _____

Part of the machine on which the accident occurred, if applicable: _____

Was safety appliance or regulation provided? Yes ☐ No ☐ Was it in use at the time: Yes ☐ No ☐

Was the accident caused by the failure to use or observe safety appliances or regulations? Yes ☐ No ☐

Describe fully how the accident occurred and state what the employee was doing when injured:

_____

_____

_____

Name of all witnesses:

_____

NATURE OF INJURY

Nature of Injury and Body Part Affected (be specific): _____

Did you seek medical treatment? Yes ☐ No ☐ Did you see the School Nurse (if applicable): Yes ☐ No ☐

If so, please provide the name and address of the physician or hospital: _____

Has the injured employee returned to work: Yes ☐ No ☐ If yes, what date and time: _____

At what occupation: _____

☐ **Check here if this was a motor vehicle accident. Police report MUST be attached.**

Please provide any doctor/hospital notes if you sought medical treatment for this injury.

ACKNOWLEDGMENT

(Injured Person must complete and sign this section)

Employee Signature: _____ Today's Date: _____

FUTURECOMP CONSENT FOR RELEASE OF MEDICAL INFORMATION

(ALL INJURED EMPLOYEES MUST COMPLETE AND SIGN THIS SECTION)

Name of Injured Employee: _____

Date of Injury: _____

Date of Birth: _____ Social Security Number: _____

I authorize the release of medical information and facts regarding this injury, including reports and records, results, or diagnosis, treatment and prognosis, estimates of disability, and recommendations for further treatment relating to this injury. This information is to be used for purpose of evaluating and handling my claim for injury as a result of an accident on or about the date of injury as identified above on this form. This will also authorize FutureComp Medical Case Manager if assigned to me to have access to all medical records and Utilization Review Records. The Case Manager may discuss pertinent information with professionals involved in my case to share information as appropriate and necessary for coordination of health care services and coordination with employer for return to work. I understand authorization for Case management purposes is voluntary and not required. I am willing that a photocopy of this authorization be accepted with the same authority as the original.

ACKNOWLEDGMENT

Employee Signature: _____ Today's Date: _____