

Employee First Report of Injury

EMPLOYEE RESPONSIBILITY

Complete a First Report of Injury and Release of Medical Information form immediately after an on the job injury occurs. Please be specific and include as much information as possible (what were you doing at the time of incident, what body part was injured, who witnessed the injury, etc). This report is essential to assist us in determining whether or not your injury qualifies you for workers compensation or Injury on Duty benefits, so timely processing is important.

If it is necessary for you to see a doctor or report to a treating facility, it is your responsibility to have the doctor complete a Return to Work form. This form must be forwarded to the Personnel Department immediately after each appointment. This form serves as a Fit for Duty form prior to a return to work.

If your injury requires treatment or time off, the Human Resources Department will send you a form that will include your claim number and information about your Claims Adjuster/Case Manager. This information should be given to any provider or treatment facility you visit. All tests, referrals, medications, appointments, etc., must be reviewed and approved by your case manager in advance. The City contracts with a third party vendor for case management services.

You may be required to be evaluated by a physician selected by the City.

SUPERVISORS RESPONSIBILITY

Please be sure that an injured employee completes the required information immediately after an injury. If an employee is unable to complete the injury report, you must complete it to the best of your ability and forward it to the Human Resources Department. The Supervisor/Department Head must complete and sign the bottom portion of the injury form.

If an injury results in death, amputation, loss of eye, or hospital stay, you must report the injury within 2 hours to hdougwillo@gloucester-ma.gov, 24 hours per day 7 days per week.

Injury reports should be sent through secure email or faxed, confidentially, at 978-282-3055. DO NOT SEND INJURY REPORTS THROUGH UNSECURE EMAIL.

Employee First Report of Injury

Name:	Social Security #: XXX-XX-_____
Address:	Date of Birth:
	Marital Status:
Telephone #:	# of Dependents:
Department:	Job Title:
Where did injury occur:	
Who was injury reported to:	
Date of Injury:	Time of Injury:
Date of Report:	Time of Report:
Describe Injury: <small>If injury results in death, amputation, loss of eye, or hospital stay, the supervisor must report the injury within 2 hours to hdougwillo@gloucester-ma.gov Please send injury reports to hdougwillo@gloucester-ma.gov through secure email only, or fax, confidentially, at 978-282-3055.</small>	
Describe how injury occurred:	
Did you seek treatment:	
Treatment Facility:	
Doctor's Name:	
<small>I swear under the penalties of perjury that the above statement is true and correct</small>	
Employee Signature _____ Date: _____	
Did anyone witness this injury?	
Name:	Address:
Name:	Address:

Supervisor/Department Head Report

How did accident occur:
Were measurers taken to prevent reoccurrence:
If yes, please explain:
Department Head Signature: _____
Date: _____
Did a copy of this report get sent to the Retirement Office <input type="checkbox"/> Yes <input type="checkbox"/> No

Authorization for Release of Medical Records

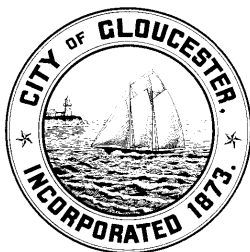
I authorize any licensed physician, medical practitioner, nurse, pharmacist, clinic, other medical or medically related facility, insurance or reinsurance company, medical or vocational rehabilitation agency, employer, or former employer that has any information as to the diagnosis, treatment, or prognosis of any physical or mental condition of myself, pertaining to my industrial accident claim, to give any and all such information to a representative of the City of Gloucester.

I know that I may request a copy of the Authorization. I agree that a photographic copy of the authorization shall be as valid as the original.

Date

Name (print)

Signature



City Hall
Nine Dale Avenue
Gloucester, MA 01930

TEL 978-281-9742
FAX 978-282-3055
HDougwillo@gloucester-
ma.gov

CITY OF GLOUCESTER
PERSONNEL DEPT

EMPLOYEE RETURN TO WORK REPORT

Employee Name

Date of office visit

I have examined this employee today and have determined that he/she is:

- Able to return to work, with no restrictions on activities.
- Unable to return to work at this time. Expected return date is _____
- Approved for work/limited duty with the following restrictions:

Current Diagnosis: _____

Date of next examination: _____

Comments: _____

Physicians Name

Physicians Signature

Address

Please contact the H.R. Department at 978-281-9742 if you have questions on concerns.