



MASSACHUSETTS EDUCATION & GOVERNMENT ASSOCIATION
SPECIALIZING IN WORKERS' COMPENSATION INSURANCE

FIRST REPORT OF INJURY

Fax to: 781-246-34

- MEDICAL ONLY- employee has sought medical treatment but has less than 5 days lost time.
LOST TIME- employee is out of work for 5 or more days
REPORT ONLY- employee has NOT sought medical treatment

*Employer: Please do not abbreviate

*Location/Address: Address where the injured employee works: (Ex. School Name & Address, DPW Address, Town/ City Address)

*Employee's Name DOB:

*Employee's Address:

*City State *Zip

Phone #: *Social Security #:

*Department: *Job Title: *Date of Hire: / /

Rate of Pay: *Date of Incident: / / Time

*Body Part: *Type of Injury (strain, laceration, etc.)

*Describe what happened:

Name of Witness (es)

To who was accident/incident reported to? Date Reported

*Was medical attention sought? Yes No If yes, *Where?

*Did employee return to work? Yes No If yes, *Date employee returned to work / /

*LOST TIME: Please provide the first day out of work because of injury / / 20

*LOST TIME: Please provide the fifth day out of work because of injury / / 20

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/Person filing out form Comments:

Supervisor/Person filing out form Signature: Date:

*Required

c/o CCMSI 55 Walkers Brook Drive, Suite 402, Reading, MA 01867

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