CITY OF LOWELL
EMPLOYEE INJURY REPORT FORM

(for reporting work-related injuries)

PLEASE PRINT THE REQUIRED INFORMATION

This report must be completed immediately by the Injured Employee and his Supervisor. This form must be forwarded to the Law Department and your Human Resource Department WITHIN 24 HOURS of any on-the-job injury.

Date of this report: ____/_____/_____ (mm/dd/yyyy) Are you expected to miss time out of work? _____
CHECK TREATMENT: _____First Aid Only ____Health Facility _____ Hospital
If First Aid is administered by the SCHOOL NURSE, the NURSE MUST COMPLTET PART C.
If injured employee was sent to a Health Care Facility or Hospital, please state the name of the facility:
_____

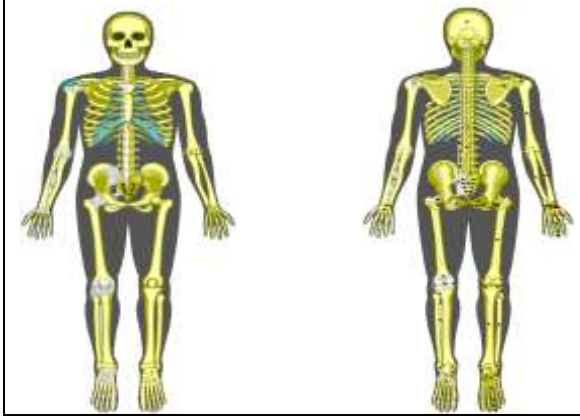
PART A: INJURED WORKER'S STATEMENT OF ACCIDENT/ILLNESS

Employee Name (Last Name, First Name):		Employee Number:	
Home address:		Home phone Cell Phone Email Address	
Date of Hire:	Date of Birth:	Hourly Wage: $	
Department Name:	Job Title/Current Position and Location:		
Date of Injury:	Time of injury: □a.m. □p.m	Specific location where injury occurred:	
How did injury happen: Attach additional paperwork if more space needed.		Regular Start Time: _____ □a.m. □p.m Regular End Time: _____ □a.m.□p.m	

Were you ever treated for a similar condition before:
□Yes □No If yes, give details:

Body part(s) injured: Please state specifically:
_____

Please circle the appropriate injured body part below:



AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

I, _____, authorize any attending physician, hospital, or other health professional and or medical provider to release and exchange information to the City of Lowell Law Dept. that is pertinent to the accident/injury/illness I incurred while at work on ____/ ____/ ____ (date of injury). This consent form shall be in effect for the duration of my workers' compensation claim and without limitation.

I am willing that a photocopy of this authorization be accepted with same authority as an original.

_____
Employee's Signature

I declare that the above statements are true under the pains and penalties of perjury.

Employee's Signature:_____ **Date:**_____

PART B: SUPERVISOR'S STATEMENT		
Date Injury was reported to you:	Location of Injury:	
Did injured worker receive medical treatment: □Yes □No If no, please explain why:	Date employee sought treatment.	Name and address of hospital or physician:
Object or machinery causing injury:		
Was there contact with any other person's blood or body fluid: □Yes □No If yes, name and address of source person:		
Causes: what causes, failures to act or conditions contributed directly to the accident?	Did weather conditions contribute to occurrence: □Yes □No If yes, what were the weather conditions:	
How could a similar occurrence be avoided:	Describe any unsafe practice:	
Action Plan: What will be done to prevent similar loss?		
Name and phone number of witnesses (if any):		
Did injured worker lose time from work:	If yes, first full day of disability:	
Has the injured worker returned to work:	If yes, date returned:	

I declare that the above statements are true under the pains and penalties of perjury.

Supervisor's Name:	Signature:
Phone ext:	Date Completed:

If the injured worker returns to work or becomes disabled after this form has been filed, it is imperative that the Law Department is notified IMMEDIATELY.

Part A is to be completed by the injured employee immediately after he/she has reported any on the job injury to his/her supervisor. All questions must be answered. The employee's signature is required.

Part A is to be verified by the Supervisor.

Part B is to be competed and signed by the supervisor. Discuss the occurrence in detail with the injured worker prior to completing this section. If you have any valid reason to believe the occurrence did not happen as described, use the word "Alleged" in your description of injury.

Part C is to be completed by School Nurse and only if first aide is administered by School Nurse.

If you have any questions regarding the filing of this form, contact the City of Lowell Law Department.

Original and three copies of the Workers' Compensation Injury Form are needed.

1. Original to: City of Lowell Law Dept. / Workers' Compensation/Claims Agent
375 Merrimack Street, 3rd Floor, Lowell, MA 01852
Phone: 978-674-4058 Fax: 978-453-1510
2. Copy to be retained with your department.
3. Copy to be forwarded to Human Relations Office.
4. Copy to be forwarded to your Retirement Board.

IT IS YOUR RESPONSIBILITY TO FILE YOUR REPORT TO THE ABOVE LOCATIONS.

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If First Aid is administered by the SCHOOL NURSE, the NURSE MUST COMPLTET PART C.

PART C: REQUIRED ATTENDING NURSE'S NOTES	
Employee Name (Last Name, First Name):	Employee Number:

S: _____

O:_____

A:_____

P:_____

I declare that the above statements are true under the pains and penalties of perjury.

Attending Nurse's Signature_____

Date:_____

In the event that first aid is administered by the school nurse, this form must be filled out completely and submitted along with Employee's Injury Report Form.