CITY OF NEWTON
EMPLOYEE NOTICE OF INJURY

INTERNAL USE ONLY

Claim # __________

Type:
Incident Only ☐
Medical Only ☐
Lost Time ☐

GENERAL INFORMATION

NAME: ______________________________
(Last, First, MI)

ADDRESS: ___________________________
Street

____
City State Zip

HOME PHONE: ( ) ___________________

CELL PHONE: ( ) ___________________

EMAIL: ______________________

JOB TITLE: _____________________

DEPARTMENT: __________________

DATE OF HIRE :__________________

SUPERVISOR: ___________________

DPT HEAD: ______________________

SS# : XXX-XX- ___________________

DOB: _____/_____/_____

DESCRIPTION OF ACCIDENT

BODY PART(S) INJURED: _______________________
Be specific right or left hand/arm/leg etc..

DATE OF ACCIDENT: ____/_____/____

TIME OF ACCIDENT: ________ AM/ PM

EXACT LOCATION/ WHERE WERE YOU WHEN INJURY OCCURRED?
____

DESCRIPTION OF ACCIDENT: **How** did this happen? **Why** did it happen?
____
____
____

SAFETY AND INJURY PREVENTION: **How can we prevent this from happening again?**
____

WITNESSES: ____

IS THIS A REOCCURRING INJURY? HAVE YOU INJURED THIS BODY PART BEFORE? YES NO
IF YES, WHO DID YOU TREAT WITH AND WHEN? ____

HAVE YOU SOUGHT MEDICAL ATTENTION FOR THIS INJURY ? YES NO

IF YES, WHAT IS THE DOCTOR'S NAME? ____

DOCTOR'S NUMBER AND FAX: ____

NOTE: ALL MEDICAL NOTES MUST BE SUBMITTED TO HUMAN RESOURCES AFTER EACH VISIT SHOULD YOU WISH THE BILLS TO BE PAID FOR UNDER WORKER'S COMPENSATION. ANY FALSE OR MISLEADING STATEMENTS, REPRESENTATION OR SUBMISSIONS AFFECTING A CLAIM FOR WORKERS' COMPENSATION ARE PUNISHABLE AS A FELONY AND/OR FINE AND CRIMINAL RESTITUTION PURSUANT TO M.G.L. c. 152 § 14.SIGNED UNDER PAINS AND PENALTIES OF PERJURY.

EMPLOYEE SIGNATURE: __________________________________ DATE: _____/_____/_____

Updated May 2016