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

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