Boston - Worker's Compensation Services
REPORT OF OCCUPATIONAL INJURY OR ACCIDENT

Please fill out this form as completely as possible and provide to Workers' Compensation Services, City Hall, Room 613, Boston, MA 02201, as soon as possible, preferably within 24 hours of the incident. PART I (Sections A to G) is to be completed by the employee. Part II (sections H and I) is to be completed by the supervisor. If you have any questions about the completion of this report or worker's compensation matters, call 617-635-3193 or email workerscompstaff@boston.gov. PLEASE PRINT OR TYPE.

PART I (Employee)

SECTION A - EMPLOYEE INFORMATION

Last Name:		First Name:	Middle Initial(s):	
Home Address:		City:	State:	Zip Code:
Home Telephone:		Cellular Phone:	Social Security #:	Sex: ☐M ☐F ☐Married ☐Single
Date of Birth: (Month/Day/Year)		Date of Hire with the City: (Month/Day/Year)	Date of Hire in Current Dept: (Month/Day/Year)	
No. Hours Worked Per Day:	No. of Days Worked Per Week/Shift:	Regular Working Days: ☐Mon ☐Tues ☐Wed ☐Thu ☐Fri ☐Sat ☐Sun	Employee ID #:	
Regular Occupation:		Occupation at time of accident:	Was employee performing regular occupation when accident occurred? ☐Yes ☐ No	
Has this employee ever claimed Workers' Compensation before? ☐Yes ☐ No			If yes, Date Worker's Comp last claimed: (Month/Day/Year)	

SECTION B - DEPARTMENT INFORMATION

Department/School/Budget Program Name:			
Department Address:	City:	State:	Zip Code:
Telephone:	Fax:		

SECTION C- INJURY/ACCIDENT INFORMATION

Date of Injury/Illness/Accident:		Time of Injury/Illness/Accident ☐a.m.☐p.m.		Date of Injury/Illness/Accident Reported:
Name of person that the injury was reported to?		Position:	Telephone No:	Was more than 4 hours of work lost on the date of injury? ☐Yes ☐ No
Will time be lost beyond the date of injury? ☐Yes ☐ No		If accident resulted in death, Date of Death:		First Lost Work Day: (Month/Day/Year)
Regular Start Time: ☐a.m. ☐p.m.	Regular End Time: ☐a.m. ☐p.m.	Did accident occur on the City Premises? ☐Yes ☐ No		Incident Location Address:
Incident Location Description (e.g. loading dock)		Witness Name:		Witness Contact Information:

SECTION D - TREATMENT, REHABILITATION, & RETURN TO WORK INFORMATION

Was the injured worker transported for treatment? ☐Yes ☐ No	If Yes, form of transportation: ☐ Ambulance ☐Drove Self ☐Supervisor ☐Other	Was any treatment given at the accident site? ☐Yes No
Name of treating Physician:	Address of treating Physician:	Date of treatment: (Month/Day/Year)
Name of treating Hospital:	Address of treating Hospital:	Date of treatment: (Month/Day/Year)
Are you a Medicare beneficiary? ☐ Yes ☐ No If yes, what is your Medicare ID#?		
Date of Return to Work (if applicable):		

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SECTION E - NATURE OF INJURY OR ILLNESS

Nature of injury or illness to body parts (burn, fracture,cut, etc.)
Specific body part(s) injured: (left shoulder, right knee, lower back, etc.)
Source of injury or illness (e.g machine, etc.)

SECTION F - THE ACCIDENT

Describe the circumstances leading up to and including the accident:

What do you think was the source of this accident? (e.g. faulty equipment, etc.)

SECTION G - EMPLOYEE'S VERIFICATION OF REPORT AND CONSENT FOR RELEASE OF MEDICAL INFORMATION

I hereby verify that all of the information contained in this report of occupational injury or accident is accurate to the best of my recollection of the circumstances leading up to and including the incident which caused the injury. I also acknowledge and provide my consent to the City of Boston Worker's Compensation Service and/or their agent to obtain medical records and reports relating to this injury.	
Employee's Name (PRINT):	Occupation:
Employee's Signature:	Date Report Completed: (Month/Day/Year)

PART II (Supervisor)

SECTION H - CORRECTIVE ACTION

To your knowledge has a follow-up investigation been conducted into this report of accident? ☐ Yes ☐ No If so, are you aware of any correction action taken to prevent a similar accident from happening? (e.g. equipment repaired etc.) ☐ Yes ☐ No

Do you have any additional recommendations for preventing injuries of this type?

SECTION I - SUPERVISOR'S ACKNOWLEDGEMENT THAT ACCIDENT WAS REPORTED

Supervisor's Name (PRINT):	Title:
Supervisor's Signature:	Date Report Completed: (Month/Day/Year)