

City of Woburn



Massachusetts

MIIA

Interlocal Insurance Association

SUPERVISOR'S REPORT OF ACCIDENT- INTAKE FORM

EMPLOYEE NAME _____ SOCIAL SECURITY # _____
EMPLOYEE ADDRESS _____
TELEPHONE #: HOME _____ WORK _____
MARITAL STATUS _____ DATE OF HIRE _____
DEPARTMENT _____ OCCUPATION _____
DATE OF BIRTH _____ SEX (M or F) _____ AVERAGE WEEKLY WAGE _____
NUMBER OF DEPENDENTS _____ DATE OF INJURY _____
DESCRIPTION OF INJURY _____
LOCATION ACCIDENT OCCURRED _____
WITNESS _____
TO WHOM WAS INJURY REPORTED TO/THEIR POSITION _____
DID EMPLOYEE LOSE TIME FROM WORK? (Y or N) _____
WAS MEDICAL TREATMENT SOUGHT? (Y or N) _____ Tax ID Number: _____
MEDICAL FACILITY _____

*****Supervisor's Complete Below*****

DESCRIPTION OF ACCIDENT; WHAT WAS EMPLOYEE DOING? WHAT HAPPENED? WHY?

CAUSE-UNSAFE ACT OR CONDITION; OBJECT/SUBSTANCE CAUSING INJURY

WAS EMPLOYEE WEARING SAFETY GEAR? YES _____ NO _____ (IF NO, EXPLAIN)

ACTION TAKEN TO PREVENT SIMILAR ACCIDENTS _____

REMARKS _____

Investigated By _____ Date _____

Reviewed By _____ Date _____

School Nurse

Supervisor