MIIA MASSACHUSETTS BASED MEMBER DRIVEN

TOWN OF GREENFIELD

SUPERVISOR'S REPORT OF ACCIDENT- INTAKE FORM

EMPLOYEE NAME_____ SOCIAL SECURITY #_____
EMPLOYEE ADDRESS_____
TELEPHONE NU:__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 _____WITNESS ADDRESS_____
TELEPHONE NU:_____
TO WHOM WAS INJURY REPORTED TO/THEIR POSITION_____
DID EMPLOYEE LOSE TIME FROM WORK? (Y or N)_____
FIRST DAY OF DISABILITY _____ FIFTH DAY OF DISABILITY_____
WAS MEDICAL TREATMENT SOUGHT?(Y or N)_____Tax ID Number:_____
MEDICAL FACILITY _____
DATE REPORTED A WORK RELATED:_____INJURY:_____BODY PART:_____

RETURN TO WORK DATE:_____

*******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