MEGA
MASSACHUSETTS EDUCATION & GOVERNMENT ASSOCIATION

FIRST REPORT OF INJURY/INCIDENT

Important - When an injury occurs at the workplace:

1 – Employee shall report the incident to his/her supervisor immediately.

2 – Employee shall complete and sign this form as soon as possible, but no more than 24 hours after the incident.

3 – Supervisor or School Nurse shall call Human Resources (508-829-1670 x 231) and give notice of the incident.

4 – Supervisor or School Nurse shall fax (508-829-1680) and then interoffice mail this form to Human Resources.

5 – In cases of non-business hour incidents, please report no later than 10:00am the next business day.

6- If medical treatment is required, after notifying his/her supervisor, the employee shall go to the emergency room for serious emergencies; for minor injuries, employee can go to their own medical provider or local

7 – Employee should bring a COPY of this form when seeking medical attention (original should be sent to Human Resources)

Check one:

☐ REPORT ONLY- employee has NOT sought/is NOT seeking medical treatment

☐ MEDICAL ONLY- employee has sought/is seeking medical treatment but has less than 5 days lost time/expected lost time

☐ LOST TIME- employee is out of work/expected to be out of work for 5 or more days

- FIRST Date out of work_____ FIFTH Date out of work_____
- Did employee Return to work? Yes_____ No_____
- If yes, *Date employee Returned to work: _____/_____/_____

Please note, the first 5 days out of work are not paid through Workers Comp and can be logged against the employee's accrued time. A request must be signed and submitted to HR by employee in order to use employees accrued time.

(* Represents required fields)

Employer: Wachusett Regional School District – X340611

*Employee's Name_____ *DOB: _____/_____/_____

*Address _____

*City_____*State_____*Zip Code_____

*Social Security #:_____ Home Phone #:_____

Email: (work): _____ (personal) _____

DOH: ____/____/_____ Rate of Pay: _____ hourly / annually

*School/Building: _____ *Position: _____

*Date of Incident _____/_____/_____ Time ____ _____ Location_____

*Body Part: _____ (**Please be specific, ie: left arm, right knee, lower back, index finger, etc)**

*Type of Injury (**ie: strain, laceration, contusion, etc**.)_____

*Describe what happened (state specific facts of incident):

_____

_____

Name of Witness(es) and witness(es) contact information:

_____

To who was accident/incident reported to? _____Date Reported____/_____/_____

***Was medical attention sought?** Yes _____ No _____ If yes, forward a copy of doctor's note to HR

If yes, *Name and Address of Provider/Facility_____

_____

Street City State Zip

Did employee Return to Work after medical attention? Yes_____ No_____

If yes: same day _____ next scheduled work day _____

Information Release

I hereby authorize The Wachusett Regional School District (or any of its authorized representatives) and 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 Comments _____

Supervisor Signature: _____ Date: _____

Fax completed form to Human Resources Department 508-829-1680,

Human Resources Use Only

Date Received in HR ____/_____/_____ Entered in iCE by _____
(HR rep initials)

DOH: _____ /_____/_____ Salary $ _____

Claim # _____

Employee Claim Information form sent: _____/_____/_____ via email

Use of accrued sick letter sent: _____/_____/_____ Returned: _____/_____/_____