

## Workers Compensation Procedures – City

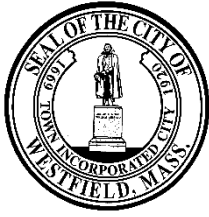
### **What to do when an injury occurs:**

1. Employee should immediately report the injury to the supervisor
2. Employee must complete the following forms at the time of reporting, if possible. Forms should be completed in their entirety, including a signature
  - a. Employee's Report of Injury Accident
  - b. Medical Authorization & Release of Information
3. Any eyewitnesses must complete Eyewitness Accident/Incident Report, if applicable
4. Call Personnel on the day of the injury to advise of the incident
5. All accident reporting forms should be completed and received by the Personnel Department no later than the next business day

### **If/When seeking medical attention:**

1. Primary source for medical attention:

Work Connection  
575 Beech St  
Holyoke, MA, 01040
2. After each and every medical/follow-up visit, the employee should be returning a form indicating their current status and treatment to Personnel. It is the employee's responsibility to make sure all medical forms are turned into Personnel after each visit.



# EMPLOYEE'S REPORT OF INJURY/INCIDENT

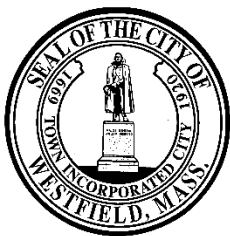
## INJURED EMPLOYEE INFORMATION

Name			Social Security Number
Address			City
		Zip Code	Home Phone Number
Date of Birth (MM/DD/YY)	Gender	Marital Status	Date of Hire (MM/DD/YY)
Social Security #		Department	
Supervisor Name		Supervisor Phone #	

## INJURY INFORMATION

Date of Injury (MM/DD/YY)	Time of Injury (AM/PM)	Date Reported (MM/DD/YY)	On Employer's Premises (Y/N)?
Address Where Injury Occurred			
Describe How Injury Occurred (e.g., struck by ..., exposed to...)			
Nature of Injury (e.g., burn, fracture, cut, etc.)			
Source of Injury (e.g., machine, tool, substance, etc.)			
Injured Body Part(s) Description (e.g., arm, leg, back, etc.)			
Name of Witnesses to the Injury			
Additional Notes/Information			

Employee Name (Print)	Supervisor Name (Print)
Signature	Signature
Date Signed (MM/DD/YY)	Date Signed (MM/DD/YY)



# MEDICAL AUTHORIZATION AND RELEASE OF INFORMATION

**EMPLOYEE:** \_\_\_\_\_

**TO:** Future Comp, USI Insurance Solutions LLC      **DATE:** \_\_\_\_\_

City of Westfield Personnel Department

City of Westfield

I, \_\_\_\_\_, hereby authorize and request any and all persons, businesses, government departments and agencies to release to my employer, the City of Westfield, and its authorized representatives, CMS Associates, Inc. any and all requested medical information concerning or related to my injury or illness designated below. This release includes but is not limited to all medial records, charts, files, diagnoses, prognoses, medications or therapies prescribed, test results, x-rays, laboratory reports and such other similar information concerning or related to my illness or injury designated below. A photocopy of this document shall serve and be as valid as the original. This release shall be good and valid until or unless withdrawn by me in writing.

I am willing that a photo static copy of this authorization be accepted with the same authority as the original.

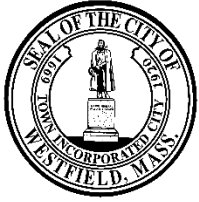
This information is to be used for purposes of evaluating and handling my line of duty/ worker's compensation injury, and for no other purpose, now or in the future.

THIS AUTHORIZATION EXPIRES ON CONCLUSION OF CLAIM.

**Injury or illness involved:** \_\_\_\_\_

**Date of injury or illness:** \_\_\_\_\_

**SIGNATURE/DATE:** \_\_\_\_\_



# EYEWITNESS ACCIDENT/INCIDENT REPORT

**NAME OF EYEWITNESS:** \_\_\_\_\_

**ADDRESS OF EYEWITNESS:** \_\_\_\_\_  
\_\_\_\_\_

**DEPARTMENT:** \_\_\_\_\_ **POSITION:** \_\_\_\_\_

**VICTIM'S NAME:** \_\_\_\_\_

**DATE OF ACCIDENT:** \_\_\_\_\_ **DATE OF REPORT:** \_\_\_\_\_

I, the undersigned, do hereby state the following with regard to an accident/incident involving the above named victim, and do so with the full knowledge of penalties under the law with respect to perjury:

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Subscribed and sworn to under the pains and penalties of perjury:

**EYEWITNESS SIGNATURE / DATE:**

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