Gowrie Claims Services
P.O. Box 578
Brant Rock, MA 02020
781.536.6920 | fax 781.536.6930
www.gowrie.com/gcs

Injured on Duty Claim Requirements

Please submit the following completed forms:

- ***Incident report***
- ***Application for 111F benefit***
- ***Medical release***

Injured on duty claim will be established upon receipt. Claim information will be provided to the Town (and/or EE) via email for treatment and billing purposes.

Thank you,

Jeanne Entwistle
jeannee@gowrie.com
p. 781.536.6922 f. 781.536.6930

SANDWICH FIRE DEPARTMENT
INCIDENT REPORT

This form must be submitted to the Human Resources Department in order to be processed.

Today's date: ________________ **Date & time of Injury:** _____________

Employer: **Town of Sandwich** **Contact tel. #:** ___________________

Employee: ____________________________ **SSN:** __________________________

Home Address: ____________________________ **DOB:** __________________________

____

____________________________ **Personal tel. #:** __________________

Nature of Injury/Illness: ____

____

Body parts affected: ____

Address where occurred: ____

Weather Conditions: ____

Incident Description: ____

____

Was medical treatment sought? [ ] Yes or [ ] No

If yes, where? ____

Employee signature: ____________________________ **Date:** _________________________

Supervisor's signature: ____________________________ Date: _________________________

Please note: Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefit or knowingly presents false information in an insurance claim application may be guilty of a crime and may be subject to fines and/or imprisonment.

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Brant Rock MA 0202
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SANDWICH FIRE DEPARTMENT
APPLICATION FOR INJURED ON DUTY STATUS

Today's date: ____________________ **Date of Injury:** ____________________

Employer: **Town of Sandwich**

Employee: ______________________________

Run/Incident#: __________________________

Time of Injury: __________________________

Witnesses (and contact information):

____

____

____

____

Are all required forms completed and submitted:

- Incident Report: [ ] Yes or [ ] No
- Medical Records Authorization [ ] Yes or [ ] No
- Doctor's Note (if applicable) [ ] Yes or [ ] No
- Return to work note (if applicable) [ ] Yes or [ ] No
- Narrative (supervisor) [ ] Yes or [ ] No
- Narrative (employee) [ ] Yes or [ ] No

- Other: ____

Employee signature: ______________________________________ Date: ____________________

Approved as IOD by Town Manager: [ ] Yes or [ ] No

Town Manager's Signature: ________________________________ Date: ____________________

Please note: All information and signatures are under penalty of perjury.

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SANDWICH FIRE DEPARTMENT
MEDICAL RELEASE AUTHORIZATION

Today's date: ______________________________

Employee: ______________________________

Date of Injury: ______________________________

To: ______________________________
____
____

This also applies to any other physicians, hospitals, clinics, or other medical providers, presently unknown to me who may have or subsequently acquire information concerning my medical condition due to this injury.

You are hereby authorized to provide to Gowrie Group, Gowrie Claims Services, Glatfelter Claims Management, or any of its representatives, all information, facts, particulars, including reports, records, results from diagnostic tests, x-rays or other images, and statements of charges which may be requested regarding my medical condition, diagnosis, treatment rendered, prognosis, estimates of disability, or recommendations for further treatment and then furnish them copies of such information. You are further authorized to allow any physician appointed by them to review all such reports, records, x-rays or other images in your possession.

I agree that a photostatic or electronic copy of this authorization be accepted with the same authority as the original.

This medical release authorization is for medical information related to this injury only. This authorization expires at the conclusion of this claim.

Employee signature: ______________________________ **Date:** ____________________

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NOTE- This form should be filed with the Retirement Board by the member or in his behalf WITHIN NINETY DAYS from the date of the accident or hazard undergone.

BARNSTABLE COUNTY RETIREMENT ASSOCIATION
750 ATTUCKS LANE
HYANNIS, MA 02601

NOTICE OF INJURY

TO THE BOARD OF RETIREMENT:

This is to notify you that ______________________ (Full name of employee) received injuries incurred through accident in the line of duty or due to a hazard which occurred in like line of duty while employed in the service at ______________________ (Unit of Employment)

on ____________ (Month, day, year) and whose home address is ______________ (Number and Street), ______________ (City or Town), ________ (Zip code)

1. __SINGLE __MARRIED __DIVORCED __ WIDOWED 1a. If married, spouse of ______________________ (Full name)

2. Date of Birth ______________ 2a. Date of entry in service ______________

3. The cause of injury was ______________________ (Describe cause of injury) (If statement requires more space use other side of this blank and write in this space-"See other side")

______________________ (Important: Sign your name after what you write on other side)

____

____

4. The nature of injury is as follows ______________________ (Describe injury with such exactness as possible)

____

IMPORTANT – No. 5, 6, 7 must not be left blank Some statement must be made. - Example – Not taken to a hospital – No witness, etc.

5. NAME AND ADDRESS OF DOCTOR WHO ATTENDED EMPLOYEE ______________ (Full name)

Address ______________ (Number and street) ______________ (City or Town) ________ (State) ________ (Zip code)

6. NAME AND ADDRESS OF HOSPITAL ______________ (Full name)

Address ______________ (Number and street) ______________ (City or Town) ________ (State) ________ (Zip code)

7. NAME AND ADDRESS OF WITNESS: (If possible give two names of eye witnesses)

1. Name ______________ Address ______________

   City or Town ______________ State ________ Zip Code ________

2. Name ______________ Address ______________

   City of Town ______________ State ________ Zip Code ________

Signature ______________________ (Of employee or other informant)

______________________ (If other informant, relationship or title of supervisor)

IMPORTANT

The Law requires that injuries incurred in line of duty AFTER JULY 1, 1938, shall be reported to the RETIREMENT BOARD WITHIN NINETY DAYS to give unlimited time coverage for (1) retirement based upon accidental injuries or (2) an accidental death benefit.

IF the NOTICE OF INJURY is not so filed WITHIN NINETY DAYS an APPLICATION for (1) accidental disability retirement, or (2) for a death benefit based upon accidental injuries incurred MORE THAN TWO YEARS PRIOR to the date of application, IS VOID. 4/2006

ACCIDENT INVESTIGATION REPORT
PART 1

Members Name:

Instructions: Supervisors should use this form to report all work-related injuries, illnesses, or "near miss" incidents - no matter the severity. This aids in the identification and correction of hazards and in the prevention of future similar type injuries from occurring. The Supervisor is responsible for contributing to all pages of this report. The Supervisor and Injured Employee must complete the EMPLOYEE's STATEMENT part of this report. All photos can be inserted as images in the Part 2 photo page. All pages must be completed.

This is a report of a work-related: ☐ Injury ☐ Illness ☐ Near Miss ☐ Fatality

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Employee Name: Department:

Supervisor's Name: Department:

Date of Occurrence: Incident Time: ☐am ☐pm

Loss of Work Time Began (if none, indicate N/A):

INJURY TYPE (Most serious, check all that apply)

☐ Burn -Heat/Chemical	☐ Strain/Sprain/Break	☐ Animal Bite/Sting	☐ Fatality
☐ Cut, Laceration, Puncture	☐ Inhalation/Reaction	☐ Skin Irritation	☐ Head Trauma
☐ Bruise	☐ Abrasion Scrape	☐ Human Bite	☐ Ambulance Transport
☐ Needlestick	☐ Eye Irritation/Cut/Scratch	☐ Illness	☐ Other
☐ Crushing Injury			Explain:

Parts of the body affected:

DESCRIPTION OF THE INCIDENT (Where, What, Why, When, etc.)

Where, exactly, did the incident occur?

What was the injured employee doing at the time of the incident?

Describe, step-by-step, what led up to the incident (i.e., EE was pruning trees, while on ladder, slipped...).

Please complete all pages

WITNESS INFORMATION (List the names, titles & dept. of anyone witness to the incident.)

Name: **Title:**

Dept./Other/Phone#:

Name: **Title:**

Dept./Other/Phone#:

Name: **Title:**

Dept./Other/Phone#:

Investigation report completed by: Date:

Employee's Supervisor: Date:

Department Head: Date:

CAUSES OF THE ACCIDENT

Using the list below, please identify cause(s) or potential cause(s) that contributed to this incident. Check all that apply.

- ☐ Improper instruction
- ☐ Lack of training or skill
- ☐ Operating without authority tool/eqpt
- ☐ Improper storage of chemicals
- ☐ Poor housekeeping
- ☐ Failure to use proper personal protective equipment
- ☐ Failure to use available tool/equipment
- ☐ Struck by person
- ☐ Struck by object
- ☐ Failure to lockout
- ☐ Inadequate lighting
- ☐ Inadequate ventilation
- ☐ Unsafe lifting
- ☐ Inoperative safety device
- ☐ Unsafe arrangement or process
- ☐ Physical or mental impairment
- ☐ Slip/Fall same level
- ☐ Slip/Fall from height
- ☐ Unsafe clothing
- ☐ Improper maintenance
- ☐ Unsafe/Defective
- ☐ Distraction
- ☐ Improper use of equipment
- ☐ Trip
- ☐ Slip/Wet or Icy surface
- ☐ Caught/Between
- ☐ Vehicle incident

Were the unsafe acts or conditions reported prior to the incident? ☐ Yes ☐ No

Have there been similar incidents or near misses prior to this one? ☐ Yes ☐ No

If 'Yes' provide explanation:

Please complete all pages

ACCIDENT PREVENTION

What changes are recommended to prevent future occurrences of similar incidents?

- ☐ Stop this activity/task
- ☐ Redesign the activity/task
- ☐ Redesign the workstation
- ☐ Train the employee(s)
- ☐ Train the supervisor(s)
- ☐ Other
  Explain:
- ☐ Enforce existing policy/procedure
- ☐ Develop a new policy/procedure
- ☐ Additional personal protective equipment
- ☐ Additional oversight by supervisor(s)
- ☐ Routinely inspect for the hazard
- ☐ No Change recommended at this time

LIST BELOW RECOMMENDATIONS FOR PREVENTION AND IMPROVEMENT

Recommendations:

What should be (or has been) done to facilitate the recommendations identified above?

EMPLOYEE'S STATEMENT

Employee needs to complete this form with along with the Supervisor to aid in the identification of hazards, deduce a corrective action and sign-off on corrective action completion.

Date of incident: Where, exactly, did the incident occur?

Describe step-by-step, what led up to the incident; and include if proper protective equipment was being worn or provided.

What/How do you feel this could have prevented this incident/injury?

Was proper training provided?

Please provide corrective action or suggestion for preventing future similar type incidents.

Employee's Signature: ______________________ Date:

Name:

Supervisor's Signature: ______________________ Date:

Name:

Please complete all pages