



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 POLICE 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 _____

DOB: _____

Address: _____

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 or a loss of benefit or knowingly presents false information in any insurance claim application may be guilty of a crime and may be subject to fines and/or imprisonment.

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**SANDWICH POLICE 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 POLICE 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 _____ received injuries incurred through accident in the
(Full name of employee)
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 _____ and whose home address is _____
(Month, day, year) (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

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)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Burn -Heat/Chemical | <input type="checkbox"/> Strain/Sprain/Break | <input type="checkbox"/> Animal Bite/Sting | <input type="checkbox"/> Fatality |
| <input type="checkbox"/> Cut, Laceration, Puncture | <input type="checkbox"/> Inhalation/Reaction | <input type="checkbox"/> Skin Irritation | <input type="checkbox"/> Head Trauma |
| <input type="checkbox"/> Bruise | <input type="checkbox"/> Abrasion Scrape | <input type="checkbox"/> Human Bite | <input type="checkbox"/> Ambulance Transport |
| <input type="checkbox"/> Needlestick | <input type="checkbox"/> Eye Irritation/Cut/Scratch | <input type="checkbox"/> Illness | <input type="checkbox"/> Other |
| <input type="checkbox"/> 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.

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

- | | |
|---|---|
| <input type="checkbox"/> Stop this activity/task | <input type="checkbox"/> Enforce existing policy/procedure |
| <input type="checkbox"/> Redesign the activity/task | <input type="checkbox"/> Develop a new policy/procedure |
| <input type="checkbox"/> Redesign the workstation | <input type="checkbox"/> Additional personal protective equipment |
| <input type="checkbox"/> Train the employee(s) | <input type="checkbox"/> Additional oversight by supervisor(s) |
| <input type="checkbox"/> Train the supervisor(s) | <input type="checkbox"/> Routinely inspect for the hazard |
| <input type="checkbox"/> Other | <input type="checkbox"/> No Change recommended at this time |

Explain:

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