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 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 any insurance claim application may be guilty of a crime and may be subject to fines and/or imprisonment.

Gowrie Claims Services
PO Box 578
Brant Rock, MA 02020
p. 781.536.6920 f. 781.536.6930
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.

Gowrie Claims Services
PO Box 578
Brant Rock MA 02020
p. 781.536.6920 f. 781.536.6930
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: __________________________

Gowrie Claims Services
PO Box 578
Brant Rock, MA 02020
p. 781.536.6920 f. 781.536.6930
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 line of duty or due to a hazard which occurred in 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 _______________________________.

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 here what you write on other side)

4. The nature of injury is as follows _______________________________.

(Describe injury with such exactness as possible)

IMPORTANT — No. 3, 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) (Number and street) (City or Town) (State) (Zip code)

6. NAME AND ADDRESS OF HOSPITAL _______________________________.

(Full name) (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 _______________________________.

City or Town _______________________________.

State _______________________________.

Zip Code _______________________________.

Address _______________________________.

Signature _______________________________.

(If other informant, relationship or title of supervisor)

Of employee or other informant)

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
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)

□ Burn -Heat/Chemical □ Strain/Sprain/Break □ Animal Bite/Sting □ Fatality  
□ Cut, Laceration, Puncture □ Inhalation/Reaction □ Skin Irritation  
□ Bruise □ Abrasion Scraper □ Human Bite  
□ Needlestick □ Eye Irritation/Cut/Scratch □ Illness  
□ Crushing Injury  

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...).
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*

Massachusetts Interlocal Insurance Association, An Interlocal Service of the Massachusetts Municipal Association
One Winthrop Square, Boston, MA 02110 • 617-426-7272 • 800-882-1498 • www.m Sistema.org