FORM 101

The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 101
600 Washington Street – 7th Floor, Boston, Massachusetts 02111
Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470
http://www.mass.gov/dia

DIA USE ONLY

EMPLOYER'S FIRST REPORT OF INJURY OR FATALITY

THIS FORM MUST BE FILED BY THE *EMPLOYER* IN THE EVENT OF AN INJURY THAT RESULTS IN DEATH OR FIVE OR MORE CALENDAR DAYS OF TOTAL OR PARTIAL INCAPACITY FROM EARNING WAGES.

***INSTRUCTIONS AND CODES ON THE REVERSE SIDE* - Please Print Legibly or Type - Unreadable forms will be returned.**

EMPLOYEE

1. Employee's Name (Last, First, MI):	2. Home Telephone Number:	3. Social Security Number*:	4. Sex: ☐ M ☐ F
5. Home Address (No., Street, City, State & Zip Code):		6. Marital Status: ☐ M ☐ S	7. No. of Dependents:
8. Date of Hire (mm/dd/yyyy):	9. Date of Birth (mm/dd/yyyy):	10. Average Weekly Wage: $ ☐ Estimated ☐ Actual	

EMPLOYER

11. Employer's Name:	12. Federal Tax I.D. Number:
13. Employer's Address (No., Street, City, State & Zip Code):	14. Employer's Telephone Number:
	15. Industry Code (See Reverse Side):
16. Workers' Compensation Insurance Carrier and Tel. No. (NOT LOCAL AGENT/ADMINISTRATOR):	17. W.C. Policy Number:
18. Self-Insured? ☐ Yes ☐ No If Yes, Self-Insurer Number:	19. Business Type : ☐ Service ☐ Wholesale ☐ Mfg. ☐ Retail ☐ Other _____

INJURY INFORMATION

20. DATE OF INJURY (mm/dd/yyyy):		
21. Was Employee Injured on Employer's Premises? ☐ Yes ☐ No	22. Location of Injury if not on Employer's Premises:	
23. FIRST day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):	**24. FIFTH day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):**	
25. If Employee has Died, Date of Death (mm/dd/yyyy):	26. Source of Injury (Chemicals, Machinery, etc.):	
27. Briefly Describe How Injury/Exposure Occurred and Body Part(s) involved:		
28. Person to Whom Injury was Reported (list position):	29. Date Reported (mm/dd/yyyy):	30. Date Reported as work related (mm/dd/yyyy):
31. Injury Code(s) / Body Part Code(s) a. to body part a. b. to body part b. c. to body part c.	32. Witness(es) to Injury - Give Full Name(s), if none state as such:	
33. Has Employee Returned to Work? ☐ Yes ☐ No	34. Date Employee Returned to Work(mm/dd/yyyy):	
35. Employee's Regular Occupation:	36. Has Employee Returned to Regular Occupation: ☐ Yes ☐ No	

37. EMPLOYER'S Name (SEE INSTRUCTIONS ON REVERSE SIDE):	38. Title:
39. EMPLOYER'S Signature (SEE INSTRUCTIONS ON REVERSE SIDE):	40. Date Prepared (mm/dd/yyyy):

*Disclosure of Social Security Number is Voluntary. It will aid in the processing of your report. Form 101 - Revised 8/2001 - Reproduce as needed.

THIS FORM DOES NOT CONSTITUTE AN EMPLOYEE'S CLAIM FOR BENEFITS UNDER WORKERS' COMPENSATION.

Member Services
53 State Street, Boston Massachusetts 02109
Toll Free (Mass) :888/266-6442
Fax: 617 753-9987

MEDICAL AUTHORIZATION

To: _____ Date:_____

_____

_____

and any other physician, hospital, clinic or medical care provider, presently unknown to me, who may have or subsequently acquire information concerning my physical condition. You are hereby authorized to give MIIA Member Services and/or any of its representatives, all information, facts and particulars, including reports, records, results from diagnostic tests, X-rays and statements of charges which may be requested regarding my medical condition, diagnosis, treatment and to furnish them copies of such reports. You are further authorized to allow any physicians appointed by them to review all such reports, records and X-rays in your possession.

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

This information is to be used for handling my claim from an occupational injury or illness occurring on or about _____ and for no other purpose, now or in the future.

This authorization is valid for the duration of the above condition.

_____ _____

(Employee's signature) (Date)

Employer:___ _____

Name of Employee:_____

SS#: _____ Date of Birth:_____

Claim #:_____ Date of Accident: _____

MIIA

Sandwich, Town of

SUPERVISOR'S REPORT OF ACCIDENT- INTAKE FORM

DATE OF INJURY:_____ TIME OF INJURY_____ ACKNOWLEDGE/DATE REPORTED_____

DESCRIPTION OF ACCIDENT; WHAT WAS EMPLOYEE DOING? WHAT HAPPENED?WHY?_____

_____

*CAUSE:_____ *NATURE:_____ *BODY PART:_____ *OCCUPATION_____

EMPLOYEE NAME_____ SOCIAL SECURITY #_____
SEX(M or F)_____ MARITAL STATUS_____ DATE OF BIRTH_____
DATE OF HIRE_____ DEPARTMENT_____
SUPERVISOR NAME _____ PHONE NUMBER_____

EMPLOYEE ADDRESS_____
TELEPHONE NUMBER: HOME_____WORK_____
CELL_____ EMAIL_____

LOCATION ACCIDENT OCCURRED_____(Include Building or School Name)
INJURED ON PREMISE YES☐ NO ☐
AVERAGE WEEKLY WAGE_____
DID EMPLOYEE LOSE TIME FROM WORK? YES☐ NO☐
NUMBER OF DEPENDENTS_____
DID EMPLOYEE RETURN TO WORK YES☐ NO☐
IF YES, DATE RETURN TO WORK:_____ Full Duty YES☐ NO☐ Modified Duty YES☐ NO☐
TIME BEGAN WORK_____
IF NO, LAST DAY WORK_____ 1ST DAY OF DISABILITY_____ 5TH DAY OF DISABILITY_____ (calendar days)

WAS MEDICAL TREATMENT SOUGHT? YES☐ NO☐
MEDICAL FACILITY _____

DATE REPORTED AS WORK RELATED:_____
WITNESS _____
TO WHOM WAS INJURY REPORTED TO _____

*******Supervisor's Complete Below*********

CAUSE-UNSAFE ACT OR CONDITION; OBJECT/SUBSTANCE CAUSING INJURY

_____

_____

WAS EMPLOYEE WEARING SAFETY GEAR? YES☐ NO ☐ IF NO, EXPLAIN)_____

ACTION TAKEN TO PREVENT SIMILAR ACCIDENTS_____

_____

REMARKS_____

_____

Investigated By_____ Date_____

Reviewed By_____ Date_____

☐ School Nurse ☐ Supervisor

***See page 2 for selection listing**
Red Font: New OSHA Require data

2/1/19

Cause	Body Part	Nature	Occupation/Job Code
STRUCK AGAINST	ABDOMEN	INSECT BITE	ADMIN ASSISTANT
STRUCK BY	ANKLE	AMPUTATION	ADMINISTRATION
FALL DIFF LEVEL	ARM	ASPHYXIATION	ANIMAL CONTROL
FALL SAME LEV.	BACK	ANIMAL BITE	CARPENTER
CAUGHT BETWEEN	BOD PTS, NEC	BURN/SCALD	CLERICAL
HOLDING PNT UP	BODY SYSTEM	CARPAL TUNNEL	CONSERV. AGENT
LIFTING	BRAIN	BURN(CHEMICAL)	COOK
LIFT OBJ LOWER	BUTTOCKS	CONCUSSION	DRIVERS NOC
CARRYING	CHEST/RIBS	INFECT. DISEASE	ELECTRICIAN
BENDING/REACH	DIGEST SYS	CONTUSION	EMT
WHEELCHAIR	EAR	CUT/PUNCTURE	EQUIP/OPERATORS
FALL ON STAIRS	ELBOW	SPLINTER	FOREMAN
FALL OUTSIDE PR	EXCRET SYS	DERMATITIS	GENERAL ADMIN
STRUCK BY DOOR	EYES	POISON IVY	GROUNDSKEEPER
HANDTOOLS	FINGER	DISLOCATION	HARBORMASTER
POWER HAND TOOL	FOOT	ELECTRIC SHOCK	HEALTH PROF
RUB/ABRADE	GROIN	FRACTURE	INSPECTOR
SPLASHING LIQ	HAND	FROSTBITE	LABORERS
FOREIGN BDY EYE	HEAD	HEARING LOSS	LIBRARIAN
STEP ON OBJ.	HEART	VISION LOSS	LIFEGUARD
CUTS/NOT NEEDLE	HEEL	HEAT EXHAUSTION	LINEHAUL (ROAD)
PUNCH NDLE DISC	HIP	HERNIA	LINEMAN
PUNCH NDLE USE	JAW	HUMAN BITES	LPN
COLL /PERSON	KNEE	HUMAN SCRATCHES	MAINTENANCE WKR
STRUCK BY PNT	LEG	INFLAM MUSCLES	MARINE WORKER
OCCUP DISEASE	LO EXTR	POISONING	MASON/PLASTERER
EXPL & FIRE	LO EXTR MULT	PNEUMOCONIOS	MECHANIC
COMM.DISEASE	LO EXTR,NEC	SUNBURN	METER READER
BODY REACTION	LOWER LEG	SPRAIN	MISC NOC
ANIMAL BITE	MOUTH	STRAINS	PAINTER
OVEREXER/STRESS	MULTIPLE PTS	ULCERATIONS	PLANT OPERATOR
ELECTRIC SHOCK	MUS/SKEL SYS	VARICOSITIES	PLUMBER
TEMP. EXTREME	NECK	HEMORRHOIDS	REFUSE COLLECT
CONTACT TOXIC	NERV SYS/STRESS	MULT.INJURIES	REFUSE DRIVER
ASSAULT	NOSE	FOREIGN BODY	SCH/BUS/DRIVER
INSECT BITE	OTH BOD SYS	MENTAL DISORDER	SCH/CAFETERIA
MOTOR VEH ACC.	PELVIS	NERV SYS/STRESS	SCH/CUSTODIAN
TRIPPED/TURNED	RESP SYS	RESP. SYSTEM	SCH/NURSE
CLIMBING	SCALP	EYE IRRITATION	SCHOOL TEACHER
PULLING HOSE	SHOULDER	PROTH DEVICE	SCHOOL/AIDE
CONTAGIOU PLANT	SKIN	OCC. DISEASE	SCHOOL/CLERICAL
SHOT	TEETH	HEART ATTACK	SCHOOL/CROSSING
HLD-UP RIOT	THIGH	HYPERTEN/STROKE	SECRETARY
ROBBERY	TOES	FAINTING	SUPERINTENDENT
HORSEPLAY/FIGHT	TRUNK	SCARRING	TEMP/OTHER
WINDBLOWN OBJ.	TRUNK MULTI	cardio/vascular	TEMP/SUMMER
REPETITIVE MOT.	UP EXTR	NOT CLASSIFIED	TREE WORKER

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

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MIIA Members Services
Workers' Compensation Prescription Information

Employer:

Please fill out employee information below and provide employee with this document to take to any pharmacy with prescriptions.

	MIIA Massachusetts Based Member Driven
MIIA Member:	Town of Sandwich
Employee Name:	
Group#:	10602826
Member ID (SSN):	
Date of Injury:	
Processor:	myMatrixx
Bin#:	014211
Day supply is limited to 30 days for a new injury.	
myMatrixx Help Desk: (877) 804-4900	

Employee:

MIIA Members Services has partnered with ***myMatrixx*** to make filling workers' compensation prescriptions easy.

This document serves as a temporary prescription card. A permanent prescription card specific to your injury will be forwarded directly to you within the next 3 to 5 business days.

Please take this letter and your prescription(s) to a pharmacy near you. myMatrixx has a network of over 64,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call myMatrixx toll free at (877) 804-4900.

IF YOU ARE DENIED MEDICATION(S) AT THE PHARMACY PLEASE CALL (877) 804-4900

Pharmacist:

Please obtain above information from the injured employee if not already filled in by employer to process prescriptions for the workers' compensation injury only.

For questions or rejections please call (877) 804-4900. Please do not send patient home or have patient pay for medication(s) before calling myMatrixx for assistance.

NOTE: Certain medications are pre-approved for this patient; these medications will process without an authorization. All others will require prior approval.

FOR ALL REJECTIONS OR QUESTIONS CALL: (877) 804-4900
