City of Brockton

FutureComp. Inc
Please report all claims via email to
Tricia.Simpson@usi.com
Also copy workerscomp@cobma.us
And copy sknight@cobma.us

REPORT OF ACCIDENT TO CITY EMPLOYEE

Date of Accident:_____ Department:_____

Day of Week/Time:_____ A.M._____ P.M._____ Date of this report:_____

NAME OF INJURED EMPLOYEE:_____

Address of Employee: _____
(Street, City, State, Zip)

Social Security #:_____ Home Telephone #:_____

Date of Birth:_____ Date of Hire:_____ Marital Status:_____

Occupation:_____ Rate of Pay:_____ _____
(Hourly) (Weekly)

DESCRIBE FULLY HOW ACCIDENT OCCURRED AND STATE WHAT EMPLOYEE WAS DOING WHEN INJURED:

_____

_____

Nature of Injury:

160 – Contusion, Crushing, Bruise _____
170 – Cut, Laceration, Puncture _____
210 – Fracture _____
300 – Scratches, Abrasions _____
Location of Injury:_____

310 – Sprain, Strain _____
900 – No Injury or Illness _____
*995 – Other Injury _____
*If other, give details:
_____

Primary body part code (i.e. finger, back, leg): _____

Secondary body part code: _____

Did employee leave work? _____ _____ Date/time left work: _____
(Yes) (No)

Did employee return to work? _____ _____ Date/time returned to work: _____
(Yes) (No)

How much time lost due to injury: _____ and/or _____
(# of hrs.) (# of days)

Probable length of disability:_____

(OVER)

Name/address of treating physician: _____

Name/address of hospital treated: _____

Prior treatment to injured body part? If so, when: _____

Name/address of witnesses: _____

_____

To whom did you report accident? _____ When?_____
(Name/Title)

_____
Signature of Employee
(Signed under penalty of perjury)

****

CONCURRENT EMPLOYMENT:

Are you currently employed by another employer? _____ _____
(Yes) (No)

If so, provide name/address/telephone # of employer: _____

_____

Job Title: _____ How long employed? _____

Brief description of job duties: _____

Rate of Pay: _____ _____ # Hours worked per week: _____
(Hourly) (Weekly)

****

MEDICAL RECORDS RELEASE AUTHORIZATION

I hereby request and authorize you to disclose to FutureComp., Inc. for the City of Brockton, any and all information you may have concerning me with respect to any illness or injury, medical history, consultation, psychiatric notes, psychological notes, prescriptions, including x-ray plates, and copies of all hospital or medical records as well as any other employment records. A photocopy of this authorization shall be considered as effective and valid as the original.

Signed: _____ Date: _____

Address: _____ Witness: _____

_____

****

Please be sure to forward all medical reports and doctor's slips to the FutureComp., Inc. If injury results in five (5) or more days lost from work, it is imperative that the Workers' Compensation Agent receives medical back-up in order to make a determination on your workers' compensation claim.

Date sent: _____
Date rec'd: _____

WORKERS' COMPENSATION

CITY OF BROCKTON

EMPLOYEE'S STATEMENT

DATE OF ACCIDENT: _____ DEPT: _____

Employee Information:

Employee Name: _____

Address: _____

Telephone: _____

D/O/B: _____ S.S.#: _____ Date of Hire: _____

Accident Information:

Location/Address of Accident: _____
_____

How did accident/injury occur: _____
_____
_____
_____
_____

What was employee doing at the time of accident/injury: _____
_____
_____
_____
_____

(OVER)

Were any defects (i.e. ice, grease, broken steps) a contributing factor to the accident/injury? If so, please comment: _____

_____

_____

_____

_____

What part(s) of the body, if any, were injured, and how: _____

_____

_____

_____

List prior medical treatment received, if applicable, for body part(s) listed above: _____

_____

Other witnesses present? If so, please provide name/address: _____

_____

_____

_____

What were you and each witness doing at the time: _____

_____

_____

_____

Further remarks or information: _____

_____

_____

_____

_____

SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY

Date: _____ Signature: _____

Form sent to: _____
Date sent: _____
Date rec'd: _____

WORKERS' COMPENSATION/INJURED ON DUTY
CITY OF BROCKTON

STATEMENT OF WITNESS

Report of injury to: _____
(Name of Employee)

Department: _____

The above-named employee alleges an incident on: _____
(Date)

**** NOTE: WITNESS'S OWN HANDWRITING FROM HERE ON ****

When did you know that this incident occurred? _____

How did you know? _____

Where were you at that time? _____

Did you actually see the incident occur? _____ Yes _____ No

What was the employee doing at the time of the alleged incident? _____

_____

_____

Describe the incident in detail: _____

_____

_____

What part(s) of the body, if any, were injured, and how? _____

_____

Did employee leave work? If so, when? _____ Yes Date/Time: _____ No _____

Any other witnesses present who actually saw the incident? _____ Yes _____ No

If yes, please provide name(s): _____

_____

(OVER)

What were you and each witness doing at the time? _____

_____

_____

Further remarks or information: _____

_____

_____

How long have you worked with injured worker? _____

SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY

Date: _____ Signature: _____

Print Name: _____

Revised 1/08