City of Somerville/Somerville Retirement Board

REPORT OF OCCUPATIONAL INJURY OR ILLNESS

This form **MUST BE COMPLETED BY THE EMPLOYEE OR SUPERVISOR IN FULL** and forwarded/faxed to Human Resources, Somerville City Hall, **WITHIN 24 HOURS OF INJURY OR ACCIDENT**. If you have any questions about the completion of this report or workers' compensation matters, call 617.625.6600 x3300, fax 617.591.3118 or email workerscomp@somervillema.gov.

PLEASE PRINT OR TYPE – ORIGINAL REPORT W/SIGNATURE MUST BE FORWARDED TO HUMAN RESOURCES

Section A – Employee Information

First Name	Middle Initial	Last Name	

Social Security Number	Gender	Birth Date (mm/dd/yyyy)	Marital Status
- -	M ☐ F ☐	/ /	

Home Address - Number & Street	City	State	Zip Code

Department	Number of Dependents

Home Phone (Area Code + Number)	Work Phone/Cell Phone/Pager (Area Code + Number)
( ) -	( ) -

Date Hired (mm/dd/yyyy)	Weekly Wage	Occupation	Annual Salary
/ /	$		$

Section B – Injury/Illness Information

Date of Injury/Illness (mm/dd/yyyy)	Time of Injury/Illness	Date Injury/Illness was reported (mm/dd/yyyy)
/ /	: ☐ am ☐ pm	/ /

Did the accident occur on employer's premises?	Weather conditions if injury occurred outdoors	Will time be lost?
☐ Yes ☐ No		☐ Yes ☐ No

Location where accident occurred	Name of person that injury was reported to

Name of witness(es) and a number where they can be contacted

Section C – Treatment, Rehabilitation and Return to Work Information

Name of Treating Physician/Hospital	Phone Number of Treating Physician/Hospital
	( ) -

Section D – Nature of Injury or Illness

Nature of injury or illness (Burn, Fracture, Cut etc.)	Body Part(s) (Arm, Leg, Back, Right or Left etc.)

Source of injury or illness (e.g. machine, etc.)

Section E – The Accident

Describe the circumstances leading up to and including the accident

Section F – Employee's Verification of Report and Consent for Release of Medical Information

I hereby verify that all the information contained in this report of occupational injury or accident is accurate to the best of my recollection of the circumstances leading up to and including the incident that caused the injury. I also acknowledge and provide my consent to the City of Somerville, Workers' Compensation Services and/or their agent to obtain medical records and reports relating to this injury.

Employee's Name (PRINT)	Employee's Signature	Date Report Completed

IMPORTANT

Law requires that injuries incurred, in the line of duty, shall be reported to the RETIREMENT BOARD within ninety (90) days to give unlimited time coverage for a retirement based upon (1) Accidental Injury or (2) Accidental Death. If the Notice of Injury is not filed within ninety (90) days, an application for such benefits based upon accidental injury/death incurred more than two years prior to the date of application is VOID.