MIIA Massachusetts Based Member Driven

Town of Milton

SUPERVISOR'S REPORT OF ACCIDENT- INTAKE FORM

EMPLOYEE NAME: _____ SOCIAL SECURITY #: _____
EMPLOYEE ADDRESS: _____
TELEPHONE NUMBER--HOME: _____ WORK: _____
MARITAL STATUS: _____ DATE OF HIRE: _____
DEPARTMENT: _____ JOB TITLE: _____
DATE OF BIRTH: _____ SEX(M or F): _____ AVERAGE WEEKLY WAGE: _____
NUMBER OF DEPENDENTS: _____ DATE OF INJURY: _____
INJURY: _____ BODY PART: _____
DESCRIPTION OF INJURY: _____
LOCATION ACCIDENT OCCURRED: _____
WITNESS NAME: _____
TO WHOM WAS INJURY REPORTED TO/THEIR POSITION:
_____
DID EMPLOYEE LOSE TIME FROM WORK? (Y or N): _____
WAS MEDICAL TREATMENT SOUGHT? (Y or N): _____
MEDICAL FACILITY: _____
DATE REPORTED AS WORK RELATED: _____ RETURN TO WORK DATE: _____

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

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