



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: <input type="checkbox"/> M <input type="checkbox"/> F
	5. Home Address (No., Street, City, State & Zip Code):			6. Marital Status: <input type="checkbox"/> M <input type="checkbox"/> S	7. No. of Dependents:
	8. Date of Hire (mm/dd/yyyy):	9. Date of Birth (mm/dd/yyyy):		10. Average Weekly Wage: \$ <input type="checkbox"/> Estimated <input type="checkbox"/> 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:	
	16. Workers' Compensation Insurance Carrier and Tel. No. (NOT LOCAL AGENT/ADMINISTRATOR):			15. Industry Code (See Reverse Side):	
	18. Self-Insured? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Self-Insurer Number:			17. W.C. Policy Number:	
				19. Business Type : <input type="checkbox"/> Service <input type="checkbox"/> Wholesale <input type="checkbox"/> Mfg. <input type="checkbox"/> Retail <input type="checkbox"/> Other _____	
INJURY INFORMATION	20. DATE OF INJURY (mm/dd/yyyy):				
	21. Was Employee Injured on Employer's Premises? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		34. Date Employee Returned to Work(mm/dd/yyyy):		
	35. Employee's Regular Occupation:		36. Has Employee Returned to Regular Occupation: <input type="checkbox"/> Yes <input type="checkbox"/> 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.



**ACCIDENT REPORTING FORM: TO BE COMPLETED BY EMPLOYEE,
REVIEWED AND SIGNED BY SUPERVISOR FOR ACCURACY**

1. EMPLOYEE Name (Last, First, MI)		2. Phone Number	3. Social Security Number
4. Home Address (No & Street, City, State Zip Code)		5. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	6. Number of Dependents
7. Date of Hire (MM/DD/YY):	8. Date of Birth (MM/DD/YY):	9. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	10. Hourly Wage \$
11. Hours Worked Per Day <input type="checkbox"/> FT <input type="checkbox"/> PT	12. Days Worked Per Week	13. Average 52-Week \$ _____ <input type="checkbox"/> Estimated <input type="checkbox"/> Actual	
14. EMPLOYER Address (No & Street, City/State/Zip)		15. Employer Telephone	16. Department Employee Works:
17. Employer Name/Insurance Carrier: Name and Address of Branch Responsible for This Case (Not Local Agent or Adjuster) City of Beverly c/o FutureComp, 12 Gill Street, Suite 5500, Woburn, MA 01801			

18. Date of Injury MM/DD/YY:	19. Time of Injury _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	20.. Source of Injury (e.g., Machine, Tool, Substance, etc.)	
21. Address/Building/School Name where Injury Occurred		22. On Employer's Premises: <input type="checkbox"/> Yes <input type="checkbox"/> No Where? i.e. stairway, parking lot, classroom, curb, street	
23. Hospital Name/Treating Doctor Name and Address		24. Regular Occupation	25. Regular Occupation when Injured? <input type="checkbox"/> Yes <input type="checkbox"/> No
26. Name of Supervisor to Whom Was Injury Reported:		27. Date Reported (MM/DD/YY):	
28. DESCRIBE IN DETAIL How Injury Occurred (<i>I was walking down stairs and.....</i>)			
29. Injured Body Part(s) Left Arm, Right Leg, Back and Hip		30. Nature of Injury(ies) (Burn, Fracture, Fall, Cut, Strain)	
31. Witnesses to the Accident			

SIGNATURES

32. EMPLOYEE'S Name/Title	33. Employee's Signature and Date (MM/DD/YY): _____ I certify this is true and accurate
34. SUPERVISOR'S Name/Title:	35. Supervisor's Signature and Date (MM/DD/YY): _____ I have reviewed this form for accuracy
36. PREPARER'S Name/Title (if Employee is unable to complete and if so, provide reason)	37. Preparer's Signature and Date _____