MEGA
MASSACHUSETTS EDUCATION & GOVERNMENT ASSOCIATION

FIRST REPORT OF INJURY/INCIDENT

Important - When an injury occurs at the workplace:

1 – Employee shall report the incident to his/her supervisor immediately.
2 – Employee shall complete and sign this form as soon as possible, but no more than 24 hours after the incident.
3 – Supervisor or School Nurse shall call Human Resources (508-829-1670 x 224) and give notice of the incident.
4 – Supervisor or School Nurse shall fax (508-829-1680) and then interoffice mail this form to Human Resources.
5 – In cases of non-business hour incidents, please report no later than 10:00am the next business day.
6- If medical treatment is required, after notifying his/her supervisor, the employee shall go to the emergency room for serious emergencies; for minor injuries, employee can go to their own medical provider or local Urgent Care facility.
7 – Employee should bring a COPY of this form when seeking medical attention (original should be sent to Human Resources)

Check one:

☐ ***MEDICAL ONLY- employee has sought/is seeking medical treatment but has less than 5 days lost time/expected lost time.***
☐ **LOST TIME- employee is out of work/expected to be out of work for 5 or more days**
☐ **REPORT ONLY- employee has NOT sought/is NOT seeking medical treatment**

(* Represents required fields)

***Employer: Wachusett Regional School District – X340611**

***Employee's Name**_____ ***DOB:** ____/_____/_____

***Address** _____

City**_____State**_____***Zip Code**_____

***Social Security #:**_____ Home Phone #:_____

Email: (work): _____ (personal) _____

DOH: ___/____/____ Rate of Pay: _____ hourly / annually

***School/Building:** _____ ***Position:** _____

***Date of Incident** ____/____/_____ Time _____ Location_____

***Body Part:** _____

***Type of Injury (strain, laceration, etc.)** _____

***Describe what happened (state specific facts):**

_____

_____

Name of Witness(es) and witness(es) contact information:

_____

To who was accident/incident reported to? _____Date Reported_____

***Was medical attention sought? Yes ___ No ____ If yes, forward a copy of doctor's note to HR**

If yes, *Name and Address of Provider/Facility_____

_____

Street City State Zip

***Did employee RTW? Yes___ No___ If yes, *Date employee RTW**_____

***LOST TIME: FIRST Date out of work**_____ **FIFTH Date out of work**_____

Please note, the first 5 days out of work will be logged against the employee's accrued time.

Information Release

I hereby authorize The Wachusett Regional School District (or any of its authorized representatives) and Massachusetts Education and Government Association Property & Casualty Group, Inc. (MEGA), or any of its representatives to be furnished any information and facts regarding medical services rendered to me by any medical provider, including reports/records, results of diagnosis, treatment and prognosis, estimates of disability and recommendations for further treatment. This information is to be used for the purpose of evaluating and handling my claim for injury as a result of an incident occurring on or about the above indicated date of injury and for no other purpose, now or in the future.

Employee Signature: _____ **Date:** _____

Supervisor Comments _____

Supervisor Signature: _____ **Date:** _____

Fax completed form to Human Resources Department 508-829-1680, then send original via interoffice mail

Human Resources Use Only

Date Received in HR _____

Entered in iCE by _____
(HR rep initials)

Claim # _____