Watertown Public Schools
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REPORTING INJURIES AT WORK

Please note, effective 7/1/2003, The Town of Watertown implemented a new Workers' Compensation program. As a result, some of the process and paperwork has changed.

Attached is the Medical Authorization form necessary for proper reporting of injuries at work. Your timely cooperation in filling out reports is a must and will expedite any referrals concerning filed reports.

On the Job Injury information

The Town of Watertown has a fully-insured Workers' Compensation program. The Town of Watertown and MIIA will be working together to ensure that Town employees have a safe environment in which to work, and to help an injured employee return to work quickly and as safely as possible.

If you are injured while on the job:

REPORT the injury to your supervisor immediately, regardless of the severity. Something you think is minor today may become major in a week and if not reported, you may not be covered.

WORK WITH YOUR SUPERVISOR TO COMPLETE forms.
The following forms must be completed in order to file a claim:
1) Supervisor's Report of Accident - Used to describe the accident
2) Medical Authorization Form (Attached) - necessary to allow the Town and its representatives to obtain all medical information relating to your work injury

The supervisor will then forward these forms to the Central Office Personnel Department.

You may use your PCP, a local hospital or the info below, use your best judgment depending on circumstances.

IF you need medical attention, the facility the Town offers is:
Mt. Auburn Hospital Occupational Health Services
777 Concord Avenue, Suite 301 Cambridge, MA 02138
617-354-0546

SEND all medical bills to the Central Office Personnel Department.
DO NOT pay medical bills directly to your provider.
DO NOT use your medical insurance card.
You **MAY** pay for prescriptions and submit the receipt to the Central Office Personnel Department for Reimbursement. However, you may receive a prescription card that when used at participating locations, will act as payment so you will incur no out of pocket expenses.
You will receive a letter with your claim number, utilization review information, and workers' compensation insurance information. Take this letter with you to each appointment.

If you are out of work due to a work-related injury, it is important to keep in touch with your supervisor on a regular basis.

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TOWN OF WATERTOWN

Massachusetts
MIIA
Interlocal Insurance Association

SUPERVISOR'S REPORT OF ACCIDENT- INTAKE FORM

EMPLOYEE NAME_____ SOCIAL SECURITY #_____
EMPLOYEE ADDRESS_____
TELEPHONE #:HOME_____WORK_____
MARITAL STATUS_____DATE OF HIRE_____
DEPARTMENT_____OCCUPATION_____
DATE OF BIRTH_____ SEX(M or F)_____AVERAGE WEEKLY WAGE_____
NUMBER OF DEPENDENTS_____DATE OF INJURY_____
DESCRIPTION OF INJURY_____
LOCATION ACCIDENT OCCURRED_____
WITNESS _____
TO WHOM WAS INJURY REPORTED TO/THEIR POSITION_____
DID EMPLOYEE LOSE TIME FROM WORK? (Y or N)_____
WAS MEDICAL TREATMENT SOUGHT?(Y or N)_____Tax ID Number:_____
MEDICAL FACILITY _____

*******Supervisor's Complete Below*********

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

Massachusetts
MIIA
Interlocal Insurance
Association

Aon Risk Services, Inc. of MA
99 High Street, Boston Massachusetts 02110
Tel: 617 753-9392 ext 241 Fax: 617.753-9987

MEDICAL AUTHORIZATION

To: _____ **Date:** _____
_____
_____

and any other physician, hospital, clinic or medical care provider, presently unknown to me, who may have or subsequently acquire information concerning my physical condition. You are hereby authorized to give Aon Risk Services of Massachusetts and the Corvel Corporation (or any of its representative), all information, facts and particulars, including reports, records, results from diagnostic tests, X-rays and statement of charges which may be requested regarding my medical condition, diagnosis, treatment and to furnish them copies of such reports. You are further authorized to allow any physicians appointed by them to review all such reports, records and X-rays in your possession.

I am willing that a photostatic copy of this authorization be accepted with the same authority as the original.

This information is to be used for handling my claim from an occupational injury or illness occurring on or about _____ and for no other purpose, now or in the future.

This authorization is valid for the duration of the above condition.

_____ _____
Employee's signature) (Date)

Employer: _____
Name of Employee: _____
SS#: _____ Date of Birth: _____
Claim #: _____ Date of Accident: _____