

TOWN OF GRENFIELD
Massamont Insurance
FIRST REPORT OF INJURY – MEDICAL ONLY
Employee Accident / Incident Report

If employee is disabled for 5 or more days from work, please complete Form 101 First Report of Injury

EMPLOYER

Name: **Town of Greenfield** Telephone #: 413-772-1577
Address: Human Resources, Town Hall Annex, 253 Main Street, Greenfield, MA 01301

EMPLOYEE

Name: _____ Telephone #: _____
Address: _____
Social Security #: _____ Date of hire: _____ Date of Birth: _____
Job Title: _____ Department: _____

INCIDENT/INJURY

Date of incident/injury: _____ Time: _____ Location: _____
Body part: _____ Type of injury (strain, laceration, etc): _____

Describe how incident/injury occurred:

Name of witness (es): _____

Supervisor to whom injury was reported: _____ Date reported: _____

Have you injured this body part in the past? Yes _____ No _____ When/How? _____

Was medical attention sought? Yes _____ No _____ If yes, where/when? _____

Have you lost time from work due to this injury? Yes _____ No _____ If yes, number of hours? _____

Information Release: I hereby authorize the Town of Greenfield and Massamont Insurance Agency, or any of its representatives to be furnished only 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 for no other purpose, now or in the future.

Employee Signature: _____ **Date:** _____

Supervisor comments: _____

Supervisor Signature: _____ **Date:** _____

Faxed to Massamont Insurance Agency _____