EMPLOYEE'S REPORT OF INJURY

FILL OUT THIS REPORT COMPLETELY AND SUBMIT IT TO YOUR SUPERVISOR WITHIN 24 HOURS. *SIGN THE CERTIFICATE AUTHORIZING RELEASE OF MEDICAL /HEALTH CARE INFORMATION AND SUBMIT IT TO YOUR SUPERVISOR WITH THIS FORM.*

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1. Name_____ 2.Social Security #_____

3. Address_____ 4.Date of Birth_____ M/F_____

5. City_____ ST_____ Zip_____ 6.Job Title_____

7. Home phone_____ 8.Work phone_____ 9.Dept_____

10. Work hours: Begin_____ End_____ 11.Work location_____

12. Supervisor_____ Dept._____

13. Working for another employer?_____ 14.Name of Employer_____

15. Date and time of injury_____ 16.Location injury occurred_____

17. Describe fully how injury occurred

18. Name the object, substance, or exposure which directly brought about your injury

19. Describe your (check one) ◯ injury ◯ disease in detail (mention body parts affected)

20. Witnesses:

Name and title_____ Work phone_____

Name and title_____ Work phone_____

21. Date, time and to whom you reported your injury_____

22. Did you lose time from work?_____ 23. If yes, date and time_____

24. Date and time you returned to work (if applicable)_____

25. Doctor(s):

Name_____

Address_____

26. Hospital(s):

Name_____

Address_____

_____

Date Signature

REPORT IS TO BE FILLED OUT BY EMPLOYEE

SUPERVISOR'S INJURY REPORT

WITHIN 24 HOURS OF NOTICE OR KNOWLEDGE OF AN INJURY, SUBMIT THE FOLLOWING:

1. Completed Employee's Report of Injury
2. Signed Certificate Authorizing Release of Medical/Health Care Information
3. Completed Supervisor's Injury Report

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1. Name of injured employee_____ Dept._____

2. Date of injury_____ 3.Type of injury_____

4. Date you received notice, or had knowledge that the injury was work related_____

5. Who informed you?_____

6. Person(s), other than those listed on the Employee's Report, who could provide further information about the incident:

Name and title_____

Work address and phone_____

Name and title_____

Work address and phone_____

List additional people, if any, on back.

7. Do you have any comments about the information on the Employee's Report?

Item Number Comments

_____

_____

_____

8. Do you have an opinion concerning the injury?_____

9. Do you feel this is a work-related compensable injury? ◯ Yes ◯ No

10. Was this an avoidable unavoidable injury? If avoidable, how?

11.If avoidable, what action(s) have or are being taken?

12. Had the person received training related to cause of injury? ◯ Yes ◯ No

13. Name and title_____ 14.Date_____

15. Signature_____

16. Work address_____ 17.Phone_____

18. Normal working hours_____

CERTIFICATE AUTHORIZING RELEASE OF MEDICAL/HEALTH CARE INFORMATION

PART 1

Employee_____ Employer_____ Insurer_____

Address_____ Address_____ Address_____

Date of Injury_____ Social Security Number_____

Brief description of injury and how it occurred

To:_____, Employee_____ PART 2

This is a request for release of medical and other health care information which is or has been obtained in connection with your injury or disease for which you are either claiming compensation or are receiving benefits. Your employer or insurer is authorized to obtain this information pursuant to 39 MRSA §52-A. Your failure to sign this release and return it to the employer in the enclosed envelope could result in a suspension of your benefits or a suspension of the hearings procedure before the Commission. The information provided is limited to medical or health care received in connection with your injury.

Authorized Employer/Insurer Representative

PART 3

CERTIFICATE AUTHORIZING RELEASE OF MEDICAL/HEALTH CARE INFORMATION

I hereby authorize the above employer or insurer to obtain from any physician or other health care provider, after payment to the provider of a reasonable fee, any written information which is or has been prepared in connection with my examination or treatment with respect to the injury described above and for which I am either receiving or claiming workers' compensation benefits.

Date Employee Signature

PART 4

To:_____, Health Care Provider_____

This is a request for all written information which is or has been prepared by you in connection with the examination or treatment of this employee for the injury described above and for which workers' compensation benefits are being paid or claimed. The employee has authorized the release of this information. See Part 3 of this form. Upon payment of a reasonable fee, 39 MRSA §52-A authorizes release to us within 10 days after receipt of our written request all written information which relates to the injury or disease for which workers' compensation benefits are claimed. The above Certificate of Authorization, signed by the employee, authorizes your release of this information to us.

Date Authorized Employer/Insurer Representative

Mailing Address: _____

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