



Gowrie Claims Services

P.O. Box 578
Brant Rock, MA 02020

781.536.6920 | fax 781.536.6930
www.gowrie.com/gcs

Injured on Duty Claim Requirements

Please submit the following completed forms:

- ***Incident report***
- ***Application for 111F benefit***
- ***Medical release***

Injured on duty claim will be established upon receipt. Claim information will be provided to the Town (and/or EE) via email for treatment and billing purposes.

Thank you,

Jeanne Entwistle

jeannee@gowrie.com

p. 781.536.6922 f. 781.536.6930

**SANDWICH FIRE DEPARTMENT
INCIDENT REPORT**

This form must be submitted to the Human Resources Department in order to be processed.

Today's date: _____

Date & time of Injury: _____

Employer: **Town of Sandwich**

Contact tel. #: _____

Employee: _____

SSN: _____

Home _____

DOB: _____

Address: _____

Personal tel. #: _____

Nature of
Injury/Illness: _____

Body parts
affected: _____

Address where
occurred: _____

Weather
Conditions: _____

Incident
Description: _____

Was medical treatment sought? Yes or No

If yes, where? _____

Employee signature: _____ Date: _____

Supervisor's signature: _____ Date: _____

Please note: Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefit or knowingly presents false information in an insurance claim application may be guilty of a crime and may be subject to fines and/or imprisonment.

**SANDWICH FIRE DEPARTMENT
APPLICATION FOR INJURED ON DUTY STATUS**

Today's date: _____

Date of Injury: _____

Employer: **Town of Sandwich**

Employee: _____

Run/Incident#: _____

Time of Injury: _____

Witnesses (and contact information):

Are all required forms completed and submitted:

- Incident Report: Yes or No
- Medical Records Authorization Yes or No
- Doctor's Note (if applicable) Yes or No
- Return to work note (if applicable) Yes or No
- Narrative (supervisor) Yes or No
- Narrative (employee) Yes or No

- Other: _____

Employee signature: _____

Date: _____

Approved as IOD by Town Manager: Yes or No

Town Manager's Signature: _____

Date: _____

Please note: All information and signatures are under penalty of perjury.

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**SANDWICH FIRE DEPARTMENT
MEDICAL RELEASE AUTHORIZATION**

Today's date: _____

Employee: _____

Date of Injury: _____

To: _____

This also applies to any other physicians, hospitals, clinics, or other medical providers, presently unknown to me who may have or subsequently acquire information concerning my medical condition due to this injury.

You are hereby authorized to provide to Gowrie Group, Gowrie Claims Services, Glatfelter Claims Management, or any of its representatives, all information, facts, particulars, including reports, records, results from diagnostic tests, x-rays or other images, and statements of charges which may be requested regarding my medical condition, diagnosis, treatment rendered, prognosis, estimates of disability, or recommendations for further treatment and then furnish them copies of such information. You are further authorized to allow any physician appointed by them to review all such reports, records, x-rays or other images in your possession.

I agree that a photostatic or electronic copy of this authorization be accepted with the same authority as the original.

This medical release authorization is for medical information related to this injury only. This authorization expires at the conclusion of this claim.

Employee signature: _____ Date: _____

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