FORM 101

The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 101
1 Congress Street, Suite 100, Boston, Massachusetts 02114-2017
Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470
http://www.mass.gov/dia

DIA USE ONLY

Print Form

EMPLOYER'S FIRST REPORT OF INJURY OR FATALITY

THIS FORM MUST BE FILED BY THE *EMPLOYER* IN THE EVENT OF AN INJURY THAT RESULTS IN DEATH OR FIVE OR MORE CALENDAR DAYS OF TOTAL OR PARTIAL INCAPACITY FROM EARNING WAGES.

***INSTRUCTIONS AND CODES ON THE REVERSE SIDE* - Please Print Legibly or Type - Unreadable forms will be returned.**

EMPLOYEE

1. Employee's Name (Last, First, MI):	2. Home Telephone Number:	3. Social Security Number*:	4. Sex: ☐ M ☐ F
5. Home Address (No., Street, City, State & Zip Code):	5a. Native Language Code: ____ Other:	6. Marital Status: ☐ M ☐ S	7. No. of Dependents:
8. Date of Hire (mm/dd/yyyy):	9. Date of Birth (mm/dd/yyyy):	10. Average Weekly Wage: $ ☐ Estimated ☐ Actual	

EMPLOYER

11. Employer's Name: Town of Sandwich	12. Federal Tax I.D. Number: 06-001-290
13. Employer's Address (No., Street, City, State & Zip Code): 130 Main Street, Sandwich, MA 02563	14. Employer's Telephone Number: 508-833-8061
	15. Industry Code (See Reverse Side):
16. Workers' Compensation Insurance Carrier and Tel. No. (NOT LOCAL AGENT/ADMINISTRATOR): MIIA, One Federal Street, Boston, MA 02110-2012	17. W.C. Policy Number: 14-265
18. Self-Insured? ☐ Yes ☑ No If Yes, Self-Insurer Number:	19. Business Type : ☐ Service ☐ Wholesale ☐ Mfg. ☐ Retail ☑ Other Municipal

INJURY INFORMATION

20. DATE OF INJURY (mm/dd/yyyy):	**20a. Insurer's Case/Claim File No.:**
21. Was Employee Injured on Employer's Premises? ☐ Yes ☐ No	22. Location of Injury if not on Employer's Premises:
23. FIRST day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):	**24. FIFTH day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):**
25. If Employee has Died, Date of Death (mm/dd/yyyy):	26. Source of Injury (Chemicals, Machinery, etc.):
27. Briefly Describe How Injury/Exposure Occurred and Body Part(s) involved:	
28. Person to Whom Injury was Reported (list position):	29. Date Reported (mm/dd/yyyy): / 30. Date Reported as work related (mm/dd/yyyy):
31. Injury Code(s) / Body Part Code(s) a. to body part a. b. to body part b. c. to body part c.	32. Witness(es) to Injury - Give Full Name(s), if none state as such:
33. Has Employee Returned to Work? ☐ Yes ☐ No	34. Date Employee Returned to Work(mm/dd/yyyy):
35. Employee's Regular Occupation:	36. Has Employee Returned to Regular Occupation: ☐ Yes ☐ No

PREPARER

37. PREPARER'S Name (SEE INSTRUCTIONS ON REVERSE SIDE):	38. PREPARER'S Title:	
39. PREPARER'S Signature (SEE INSTRUCTIONS ON REVERSE SIDE):	40. Date Prepared (mm/dd/yyyy):	40a. PREPARER'S e-mail address:

*Disclosure of Social Security Number is Voluntary. It will aid in the processing of your report. Form 101 - Revised 7/2010 - Reproduce as needed.

THIS FORM DOES NOT CONSTITUTE AN EMPLOYEE'S CLAIM FOR BENEFITS UNDER WORKERS' COMPENSATION.

EMPLOYER'S FIRST REPORT OF INJURY OR FATALITY

FILING INSTRUCTIONS

1. WHEN TO FILE: File this form within 7 calendar days, not including Sundays and legal holidays, of receipt of notice of any injury alleged to have arisen out of and in the course of employment, which totally or partially incapacitates an employee for a period of 5 or more calendar days from earning wages. This form is not an admission of liability, but must be filed even though the Employer may believe that the Employee is not injured, or that the Employee is not entitled to benefits under M.G.L. Chapter 152.
2. WHERE TO FILE: This form should be mailed to the Department of Industrial Accidents at the address shown on the front of the form. Copies must also be provided to the Employee and to the Employer's Workers' Compensation insurer.
3. PENALTIES: Failure to report injuries on this form may result in a fine of $100.00 in accordance with M.G.L. Chapter 152, Section 6.
4. EMPLOYER'S NAME & SIGNATURE IN BOXES 37 & 39: This form must be filed by the employer or an authorized agent/representative of the employer.

NATIVE LANGUAGE CODES

1 – English / 2 – Portuguese / 3 – Haitian Creole / 4 – Spanish / 5 – Chinese / 6 – Vietnamese / 7 – Cape Verdean / 9 – Other

INDUSTRY CODES

Agriculture, Forestry and Fishing
01 Agriculture Production - Crops
02 Agriculture Production - Livestock
07 Agricultural Services
08 Forestry
09 Fishing, Hunting and Trapping

Mining
10 Metal Mining
12 Coal Mining
13 Oil and Natural Gas
14 Nonmetallic Minerals, Except Fuels

Construction
15 General Building Contractors
16 Heavy Construction, Ex. Building
17 Special Trade Contractors

Manufacturing
20 Food and Kindred Products
21 Tobacco Products
22 Textile Mill Products
23 Apparel and Other Textile Products
24 Lumber and Wood Products
25 Furniture and Fixtures
26 Paper and Allied Products
27 Printing and Publishing
28 Chemicals and Allied Products
29 Petroleum and Coal Products
30 Rubber and Misc. Plastic Products
31 Leather and Leather Products
32 Stone, Clay and Glass Products
33 Primary Metal Industries
34 Fabricated Metal Products
35 Industrial Machinery and Equipment
36 Electronic and Other Electrical Equipment
37 Transportation Equipment
38 Instruments and Related Products
39 Miscellaneous Manufacturing Industries

Transportation and Public Utilities
40 Railroad Transportation
41 Local and Interurban Passenger Transit
42 Trucking and Warehousing
43 U.S. Postal Service
44 Water Transportation
45 Transportation by Air
46 Pipelines, Except Natural Gas
47 Transportation Services
48 Communications
49 Electric, Gas and Sanitary Services

Wholesale Trade
50 Wholesale Trade - Durable Goods
51 Wholesale Trade - Non-durable Goods

Retail Trade
52 Building Materials and Garden Supplies
53 General Merchandizing
54 Food Stores
55 Automotive Dealers and Service Stations
56 Apparel and Accessory Stores
57 Furniture and Home Furnishing Stores
58 Eating and Drinking Establishments
59 Miscellaneous Retail

Finance, Insurance and Real Estate
60 Depository Institutions
61 Non-depository Institutions
62 Security and Commodity Brokers
63 Insurance Carriers
64 Insurance Agents, Brokers and Service
65 Real Estate
67 Holding and Other Investment Officers

Services
70 Hotels and Other Lodging Places
72 Personal Services
73 Business Services
75 Auto Repair Services and Parking
76 Miscellaneous Repair Services
78 Motion Pictures
79 Amusements and Recreation Services
80 Health Services
81 Legal Services
82 Educational Services
83 Social Services
84 Museums, Botanical, Zoological Gardens
86 Membership Organizations
87 Engineering and Management Services
88 Private Households
89 Services, NEC

Public Administration
91 Executive, Legislative and Garden
92 Justice, Public Order, and Safety
93 Finance, Taxation, and Monetary Benefits
94 Administration of Human Services
95 Environmental Quality and Housing
96 Administration of Economic Program
97 National Security and International Affairs

Non-classifiable Establishments
99 Non-classifiable Establishments

NATURE OF INJURY OR ILLNESS CODES

100 Amputation or Enucleation
110 Asphyxia or Strangulation Etc
120 Burns (Heat)
130 Burns (Chemical)
140 Concussion
160 Contusion, Crushing, Bruise
170 Cut, Laceration, Puncture
190 Dislocation
200 Electric Shock, Electrocution
210 Fracture
250 Hernia, Rupture
300 Scratches, Abrasions
310 Sprains, Strains
400 Multiple Injuries
900 No Injury
950 Damage to Prosthetic Devices
995 No Other Injury, NEC**
999 Non-classifiable

Infective or Parasitic Disease
150 Infective or Parasitic Disease, UNS*
151 Amebiasis
152 Anthrax
153 Brucellosis
154 Conjunctivitis and Opthalmia
156 Tetanus
157 Tuberculosis
159 Other Infective or Parasitic Diseases

Dermatitis
180 Dermatitis, UNS*
183 Primary Infections of the Skin
184 Other Skin Conditions
185 Dermatitis, Allergenic or Contact
189 Skin Condition, NEC**

Poisoning Systemic
270 Poisoning, Systemic, UNS*
271 Due to Toxic Materials other than Lead
272 Diseases of the Blood and Blood Forming Organs
273 Upper Respiratory Conditions
274 Influenza, Pneumonia, Etc.
276 Other Diseases of the Gastro-Intestinal Tract
278 Effects of Lead
279 Other Toxic Effects of One System Only

Respiratory Systems, Conditions of
570 Respiratory Systems, Conditions of
571 Upper Respiratory
572 Asthma, Influenza, Pneumonia

Pneumoconiosis
280 Pneumoconiosis
281 Aluminosis
282 Anthracosis
283 Asbestosis
284 Byssinosis
285 Siderosis
286 Silicosis
287 Other Pneumoconioses
289 Pneumoconiosis and Tuberculosis

Nervous System, Conditions of
560 Nervous System, Conditions of - NEC**
561 Diseases of the Central Nervous System
562 Diseases of the Nerves and Peripheral Ganglia

Neoplasm Tumor
550 Neoplasm Tumor, UNS*
551 Malignant
552 Benign

Radiation Effects
290 Radiation Effects, UNS*
291 Non-Ionizing Radiation
292 Microwaves
293 Ionizing Radiation - X-Ray
294 Ionizing Radiation - Isotopes
295 Welder's Flash

Other
265 Carpal Tunnel Syndrome
510 Cardiovascular and Other Conditions of the Circulatory System
520 Complications Peculiar to Medical Care
500 Effects of Changes in Atmospheric Pressure
240 Effects of Environmental Heat
220 Effects of Exposure to Low Temperature
530 Eye, other Diseases of the Eye
230 Hearing Loss or Impairment
991 Heart Condition ,Excludes Heart Attack
320 Hemorrhoids
330 Hepatitis, Serum and Infective
275 Hepatitis, Toxic
260 Inflammation of Joints, Etc
540 Mental Disorders
900 No Illness
999 Non-classifiable
990 Occupational Disease, NEC**
580 Symptoms and Ill-defined Conditions

BODY PART AFFECTED CODES

Head
100 Head, UNS*
110 Brain
120 Ear(s), UNS*
121 Ear(s), External
124 Ear(s), Internal
130 Eye(s), UNS*
140 Face, UNS*
141 Jaw, Chin
144 Mouth and Throat (vocal chords, larynx)
146 Nose
148 Face, Multiple Parts
149 Face, NEC**
150 Scalp
160 Skull
198 Head Multiple
200 Neck & Cervical Vertebrae

UPPER EXTREMITIES
300 Upper Extremities, NEC**
310 Arm(s), UNS*
311 Upper Arm
313 Elbow(s)
315 Forearm(s)
318 Arm(s), Multiple
319 Arm(s), NEC**
320 Wrist(s)
330 Hand(s), Not Wrists or Fingers
340 Finger(s)
398 Upper Extremities, Multiple
400 Trunk, UNS*
410 Abdomen, Internal Organs, Inguinal Hernia
420 Back
430 Chest, Ribs, Breastbone, Internal Organs
440 Hip(s)..,Pelvis, Organs and Buttocks
450 Shoulder(s)
498 Trunk, Multiple

LOWER EXTREMITIES
500 Lower Extremities
510 Leg(s), UNS*
513 Knee(s)
515 Lower Leg(s)
518 Leg(s), Multiple
519 Leg(s), NEC**
520 Ankle(s)
530 Foot or Feet, Not Ankle
540 Toe(s)
598 Lower Extremities, Multiple
700 MULTIPLE PARTS
Applies when more than one major body part as been effected such as an arm and a leg
999 NON-CLASSIFIABLE - Insufficient information to identify part of body effected. Includes damage to prosthetic devises.

***UNS - UNSPECIFIED**

****NEC - NOT ELSEWHERE CLASSIFIED**

Member Services
One Federal Street, Boston Massachusetts 02110
Toll Free (Mass) :888/266-6442
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 MIIA Member Services and/or any of its representatives, all information, facts and particulars, including reports, records, results from diagnostic tests, X-rays and statements 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 photo static 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:___TOWN OF SANDWICH _____
Name of Employee:_____
SS#: _____ Date of Birth: _____
Claim #:_____ Date of Accident: _____

MIIA MASSACHUSETTS BASED MEMBER DRIVEN

TOWN OF SANDWICH

SUPERVISOR'S REPORT OF ACCIDENT- INTAKE FORM

EMPLOYEE NAME_____ SOCIAL SECURITY #_____
EMPLOYEE ADDRESS_____
TELEPHONE NU:__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 _____WITNESS ADDRESS_____
TELEPHONE NU:_____
TO WHOM WAS INJURY REPORTED TO/THEIR POSITION_____
DID EMPLOYEE LOSE TIME FROM WORK? (Y or N)_____
FIRST DAY OF DISABILITY _____ FIFTH DAY OF DISABILITY_____
WAS MEDICAL TREATMENT SOUGHT?(Y or N)_____Tax ID Number:_____
MEDICAL FACILITY _____
DATE REPORTED A WORK RELATED:_____INJURY:_____BODY PART:_____

RETURN TO WORK DATE:_____

*******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

NOTE- This form should be filed with the Retirement Board by the member or in his behalf WITHIN NINETY DAYS from the date of the accident or hazard undergone.

BARNSTABLE COUNTY RETIREMENT ASSOCIATION
750 ATTUCKS LANE
HYANNIS, MA 02601

NOTICE OF INJURY

TO THE BOARD OF RETIREMENT:

This is to notify you that _____ received injuries incurred through accident in the
(Full name of employee)
line of duty or due to a hazard which occurred in like line of duty while employed in the service at _____
(Unit of Employment)
on _____ and whose home address is _____, _____, _____
(Month, day, year) (Number and Street) (City or Town) (Zip code)

1. __SINGLE __MARRIED__ DIVORCED__ WIDOWED 1a. If married, spouse of _____
(Full name)
2. Date of Birth _____ 2a. Date of entry in service _____

3. The cause of injury was _____
(Describe cause of injury) (If statement requires more space use other side of this blank and write in this space-"See other side")

_____
(Important: Sign your name after what you write on other side)

_____

_____

4. The nature of injury is as follows _____
(Describe injury with such exactness as possible)

_____

_____

IMPORTANT – No. 5, 6, 7 must not be left blank Some statement must be made. - Example – Not taken to a hospital – No witness, etc.

5. NAME AND ADDRESS OF DOCTOR WHO ATTENDED EMPLOYEE _____
(Full name)
Address _____
(Number and street) (City or Town) (State) (Zip code)

6. NAME AND ADDRESS OF HOSPITAL _____
(Full name)
Address _____
(Number and street) (City or Town) (State) (Zip code)

7. NAME AND ADDRESS OF WITNESS: (If possible give two names of eye witnesses)

1. Name _____ Address _____

   City or Town _____ State _____ Zip Code _____

2. Name _____ Address _____

   City of Town _____ State _____ Zip Code _____

Signature _____
(Of employee or other informant)

_____
(If other informant, relationship or title of supervisor)

IMPORTANT

The Law requires that injuries incurred in line of duty AFTER JULY 1, 1938, shall be reported to the RETIREMENT BOARD WITHIN NINETY DAYS to give unlimited time coverage for (1) retirement based upon accidental injuries or (2) an accidental death benefit.

IF the NOTICE OF INJURY is not so filed WITHIN NINETY DAYS an APPLICATION for (1) accidental disability retirement, or (2) for a death benefit based upon accidental injuries incurred MORE THAN TWO YEARS PRIOR to the date of application, IS VOID. 4/2006