MIIA Nonprofit Locally based Member driven
Serving Massachusetts communities since 1982

Newburyport, City of

SUPERVISOR'S REPORT OF ACCIDENT- INTAKE FORM

DATE OF INJURY:_____TIME OF INJURY_____ ACKNOWLEDGE/DATE REPORTED_____

DESCRIPTION OF ACCIDENT; WHAT WAS EMPLOYEE DOING? WHAT HAPPENED?WHY?_____

_____

*CAUSE:_____*NATURE:_____ *BODY PART:_____*OCCUPATION_____

EMPLOYEE NAME_____ SOCIAL SECURITY #_____
SEX(M or F)_____ MARITAL STATUS_____ DATE OF BIRTH_____
DATE OF HIRE_____ DEPARTMENT_____
SUPERVISOR NAME _____ PHONE NUMBER_____

EMPLOYEE ADDRESS_____
TELEPHONE NUMBER: HOME_____WORK_____
CELL_____ EMAIL_____

LOCATION ACCIDENT OCCURRED_____(Include Building or School Name)
INJURED ON PREMISE YES☐ NO ☐
AVERAGE WEEKLY WAGE_____
DID EMPLOYEE LOSE TIME FROM WORK? YES☐ NO☐
NUMBER OF DEPENDENTS_____
DID EMPLOYEE RETURN TO WORK YES☐ NO☐
IF YES, DATE RETURN TO WORK:_____ Full Duty YES☐ NO☐ Modified Duty YES☐ NO☐
TIME BEGAN WORK_____
IF NO, LAST DAY WORK_____1ST DAY OF DISABILITY_____5TH DAY OF DISABILITY_____ (calendar days)

WAS MEDICAL TREATMENT SOUGHT? YES☐ NO☐
MEDICAL FACILITY _____

DATE REPORTED AS WORK RELATED:_____
WITNESS _____
TO WHOM WAS INJURY REPORTED TO _____

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

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

***See page 2 for selection listing**
Red Font: New OSHA Require data

2/1/19