



OFFICE OF HUMAN RESOURCES – Benefits Administration

NOTICE OF INJURY REPORT

This form is intended for internal use for all Human Resources Division/Workers' Compensation Unit user agencies and must be completed in its entirety. All Notice of Injury Reports must be electronically filed via eServices within 48 hours of an Industrial Accident. Please print clearly.

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Soc. Sec. #: XXX-XX-\_\_\_\_\_ Date of Injury: \_\_\_\_\_

Department: \_\_\_\_\_

Name: \_\_\_\_\_  
(First) (Middle) (Last)

Sex: Male Female Employee ID#: \_\_\_\_\_ Record #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Marital Status: S M

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State Hire Date: \_\_\_\_\_ Department Hire Date: \_\_\_\_\_

Status: Full-Time Employee Part-Time Employee Work Hours/Wk: \_\_\_\_\_

Shift 1st 2nd 3rd Number of scheduled days off per week: \_\_\_\_\_

Occupation: (Official Position Title) \_\_\_\_\_

Functional Title: \_\_\_\_\_

Payroll Funding Source: State Payroll Trust Funded Federal Funded

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Injury Time: \_\_\_\_\_ am / pm Date Reported: \_\_\_\_\_

Time work began on day of event: \_\_\_\_\_ am / pm

Event occurred: Before During After Work Shift 3rd Party Claim: Yes No

Describe how injury/illness occurred:  
What was employee doing (eg, pouring cleaning solution into a bucket):  
\_\_\_\_\_

How did the injury/illness occur (eg, cleaning solution splashed):  
\_\_\_\_\_

What was the source of the injury/illness (eg, cleaning solution):  
\_\_\_\_\_

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Nature of Injury/Illness (eg, chemical burn to right eye):

\_\_\_\_\_

Body part(s) affected (include right, left or both):

\_\_\_\_\_

Injury Detail: Use drop down menu below for selection, otherwise see page 5.

Select Body Part(s):

Select Injury:

Select One or More Injury Categories:

- |  |                                |                              |
|--|--------------------------------|------------------------------|
| Fall                                     | Lifting                        | MVA (Motor Vehicle Accident) |
| Assault                                  | Exposure to Harmful Substances | Repetitive Use               |
| Equipment                                | Moving/Walking                 | Stress/Heart Attack          |
| Burn                                     | Cut                            | Restraint                    |
| Needlestick/Bloodborne Pathogen Exposure | Other _____                    |                              |

Severity of Injury or Illness:

- (1) Minor injury; no likely lost time; no likely medical bills
- (2) Small injury; no likely lost time; possible medical bills
- (3) Moderate injury; possible lost time; probable medical bills
- (4) Significant injury; probably 0 – 5 days of lost time and medical bills
- (5) Severe injury; probably 5 plus days lost time and medical bills

Where the Injury Occurred:

Building: \_\_\_\_\_

Injury Location: \_\_\_\_\_

Example: stairwell, south walkway, office

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Was the incident the result of a violent act? Yes No

Was the claimant engaging in usual job activities? Yes No

If no, explain: \_\_\_\_\_

\_\_\_\_\_

Injury reported to: \_\_\_\_\_

(Name, Title)

Did the Injured / Ill worker:

- |  |     |    |
|--|-----|----|
| a. Lose consciousness?   | Yes | No |
| b. Require medical treatment more than first aid?  | Yes | No |
| c. Have an injury from a contaminated needlestick or other sharp device?                   | Yes | No |
| d. Have a significant work-related injury/illness diagnosed by a health care professional? | Yes | No |
| e. Require transfer to another job or modified duty?                                       | Yes | No |

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If employee died as a result of injury/illness, what was the date of death? \_\_\_\_/\_\_\_\_/\_\_\_\_

**Supervisor:** Are you satisfied that the injury occurred as stated? Yes No

If no, explain: \_\_\_\_\_  
\_\_\_\_\_

**Manager:** Are you satisfied that the injury occurred as stated? Yes No

If no, explain: \_\_\_\_\_  
\_\_\_\_\_

Was the incident witnessed? Yes No

If yes, provide the names of witnesses and ask that each prepare a witness statement.

Witness: Name \_\_\_\_\_ Title \_\_\_\_\_ Phone \_\_\_\_\_  
Name \_\_\_\_\_ Title \_\_\_\_\_ Phone \_\_\_\_\_

Did employee seek medical attention? Yes No

If yes, where?

a. Facility: \_\_\_\_\_  
b. Address: \_\_\_\_\_  
(street, town, zip code)

Did the employee seek medical attention away from the worksite? Yes No

Was the employee treated in an emergency room? Yes No

Was the employee hospitalized overnight as an in-patient? Yes No

Do you feel the employee would benefit from any referral to Rehabilitation? Yes No Unknown

Do you feel claim warrants further investigation? Yes No

Please attach if possible any information you feel would be useful to HRD/WC Section (i.e. claimant's job description, etc.) in managing this claim.

\_\_\_\_\_  
Supervisor Signature Please print name

Title: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Employee Signature Date: \_\_\_\_\_



OFFICE OF HUMAN RESOURCES – Benefits Administration

WORKERS' COMPENSATION
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Employee's Name: \_\_\_\_\_

Social Security Number XXX-XX-\_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Employing Agency and Location: Westfield State University, 577 Western Ave, Westfield, MA 01085

Date of injury: \_\_\_\_\_
mm/dd/yyyy

I am filing a claim for workers' compensation benefits and hereby authorize any hospital or other medical provider to release to the Human Resources Division (HRD), Workers' Compensation Section, any and all information relative to my claim for benefits, including, but not limited to, psychiatric records, records pertaining to HIV (AIDS) or other records especially those protected by law. I understand that HRD may share this information with my employer, medical and or vocation rehabilitation consultants, utilization review consultants, physicians and other medical care providers and other state agencies involved in the workers' compensation process and I hereby authorize such release to the other persons and entities described.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Body Parts List

<b>Head</b>	Hip/Buttocks/Groin (Buttocks)	<b>Upper Extremities</b>
Brain	Hip/Buttocks/Groin (Groin)	Arm(s), unspecified (Left)
Ear(s), unspecified	Hip/Buttocks/Groin (Hips)	Arm(s), unspecified (Right)
Ear(s), external	Shoulder(s) (Left)	Arm(s), unspecified (Both)
Ear(s), internal	Shoulder(s) (Right)	Arm(s), unspecified (Armpit)
Eye(s) (Left)	Shoulder(s) (Both)	Arm(s), upper (Left)
Eye(s) (Right)	Trunk, Multiple	Arm(s), upper (Right)
Eye(s) (Both)	<b>Lower Extremities</b>	Arm(s), upper (Both)
Face, unspecified	Leg(s), unspecified (Left)	Elbow(s) (Left)
Jaw, Chin	Leg(s), unspecified (Right)	Elbow(s) (Right)
Mouth & Throat (Lips)	Leg(s), unspecified (Both)	Elbow(s) (Both)
Mouth & Throat (Multiple)	Knee(s) (Left)	Arm(s), lower (forearm) (Left)
Mouth & Throat (Tongue)	Knee(s) (Right)	Arm(s), lower (forearm) (Right)
Mouth & Throat (Tooth/teeth)	Knee(s) (Both)	Arm(s), lower (forearm) (Both)
Mouth & Throat (Unspecified)	Leg(s), lower (e.g. calf, shin) (Left)	Arm(s), multiple (Left)
Mouth & Throat (Internal (e.g. vocal cords, larynx))	Leg(s), lower (e.g. calf, shin) (Right)	Arm(s), multiple (Right)
Nose	Leg(s), lower (e.g. calf, shin) (Both)	Arm(s), multiple (Both)
Face, multiple	Leg(s), multiple (Left)	Wrist(s) (Left)
Face (Cheeks)	Leg(s), multiple (Right)	Wrist(s) (Right)
Face (Forehead)	Leg(s), multiple (Both)	Wrist(s) (Both)
Scalp	Leg(s), upper (e.g. thigh, hamstring) (Left)	Hand(s), not wrist/fingers (Left)
Skull	Leg(s), upper (e.g. thigh, hamstring) (Right)	Hand(s), not wrist/fingers (Right)
Head, Multiple	Leg(s), upper (e.g. thigh, hamstring) (Both)	Hand(s), not wrist/fingers (Both)
Head	Ankle (Left)	Finger(s)
<b>Neck</b>	Ankle (Right)	Upper Extremities, multiple (Left)
Neck & cervical vertebrae	Ankle (Both)	Upper Extremities, multiple (Right)
<b>Trunk</b>	Foot or Feet, except ankle/toe (Left)	Upper Extremities, multiple (Both)
Trunk, UNS	Foot or Feet, except ankle/toe (Right)	<b>Other</b>
Abdomen, internal organs/hernia	Foot or Feet, except ankle/toe (Both)	Other (Body system)
Back	Toe(s)	Other (Multiple body parts)
Chest/Breastbone (Internal organs)	Lower Extremities, multiple (Left)	Non-Classifiable
Chest/Breastbone (Ribs, breastbone)	Lower Extremities, multiple (Right)	
	Lower Extremities, multiple (Both)	

## List of Injury Types

<b>Acute Injuries</b>	<b>Mental disorders</b>
Amputation, enucleation	Mental disorders (Anxiety attacks)
Asphyxia, suffocation	Mental disorders (Other mental disorder or syndrome)
Burn, heat	Mental disorders (Stress)
Burn, chemical	<b>Other Work-related diseases/disorders</b>
Concussion	Other occupational disease
Contusion, crushing, bruise	Diseases of central nervous system
Cut, laceration, puncture (Except needlestick injury)	Diseases of peripheral nerves and ganglia
Cut, laceration, puncture (Needlestick/sharp injury )	Disease of the blood and blood forming organs
Cut, laceration, puncture (Splinter, chip (foreign body))	Disease of the gastro-intestinal tract
Dislocation	Carpal tunnel syndrome
Fracture	<b>Poisoning and toxic effects</b>
Effects of exposure to low temperature	Other poisoning due to toxic materials
Effects of environmental heat	Effects of lead
Hernia, rupture	<b>Respiratory conditions</b>
Effects of radiation	Other respiratory condition
Scratches, abrasion	Upper respiratory condition (e.g. allergic rhinitis)
Sprains, strains	Asthma
Multiple injuries	Asbestosis
Effects of atmospheric pressure	Silicosis
Bite/Burn/Other Injury (Bite, animal)	Influenza/Pneumonia (Influenza)
Bite/Burn/Other Injury (Bite, human)	Influenza/Pneumonia (Pneumonia)
Bite/Burn/Other Injury (Bite, insect)	<b>Skin conditions</b>
Bite/Burn/Other Injury (Burn, other)	Dermatitis
Bite/Burn/Other Injury (Other injury)	Infections of the skin
Electric shock/electrocution	Other skin conditions
<b>Heart/Circulatory System Conditions</b>	<b>Tumor, cancer</b>
Heart/Circulatory System (Heart condition/attack)	Tumor, unspecified
Heart/Circulatory System (High blood pressure)	Malignant Tumor
Heart/Circulatory System (Stroke or other circulatory condition)	Benign Tumor
<b>Hearing and eye disorders</b>	<b>Symptoms, ill defined conditions</b>
Hearing loss or impairment	Symptoms, ill defined conditions (Back pain, hurt back)
Conjunctivitis	Symptoms, ill defined conditions (Chest pains)
Other diseases of the eye	Symptoms, ill defined conditions (Dizziness)
<b>Infectious or parasitic diseases</b>	Symptoms, ill defined conditions (Headaches, migraine)
Tetanus	Symptoms, ill defined conditions (Nausea, vomiting)
Tuberculosis	Symptoms, ill defined conditions (Pain/Soreness, except back or chest)
Infectious/Parasitic Diseases (Lyme disease)	Symptoms, ill defined conditions (Sick building syndrome)
Infectious/Parasitic Diseases (Other infectious or parasitic diseases)	Symptoms, ill defined conditions (Other symptoms and ill defined conditions)
Hepatitis - viral	<b>Other</b>
<b>Inflammation of the joints or tendons</b>	No injury or illness
Joint Inflammation, etc. (Arthritis)	Damage to prosthetic devices
Joint Inflammation, etc. (Bursitis)	Non-classifiable (Exposure to saliva/body fluids)
Joint Inflammation, etc. (Other Inflammation of the joints)	Non-classifiable (Non-classifiable)
Joint Inflammation, etc. (Sciatica)	Complications peculiar to medical care
Joint Inflammation, etc. (Tendonitis)	