INITIAL INJURY REPORT FORM

Instructions: This form is to be completed by the employee and their supervisor within 24 hours of any employee injury at work, and submitted by the Human Resource Office. Human Resources will, upon receipt, call in the injury to the Beacon Mutual Insurance, Co., One Beacon Centre, Warwick, RI 02886 for review and determination on the claim.

Employees must inform their health care provider that Beacon is the Town's Worker's Compensation carrier. For lost time injuries, the employee must present a fitness for duty certificate to their direct Supervisor prior to return to work. Upon receipt, the Supervisor will forward a copy to Human Resources to submit to Beacon.

EMPLOYEE REPORT

Last Name: _____ First Name: _____ MI _____ Date of Birth / / Age _____

Full Address (No&Street) _____ City _____ State _____ Zip _____

Social Security No. _____ Sex: ☐ M ☐ F Phone No.: ( ) _____

Date of Hire _____ Job Title _____ Department _____ B/C ID No. _____

Location of Incident _____ Time work day began _____ ☐ am ☐ pm

Date of Incident _____ Time of Incident _____ ☐am ☐pm

Did you receive this injury while working for the Town of Westerly? ☐Yes ☐No

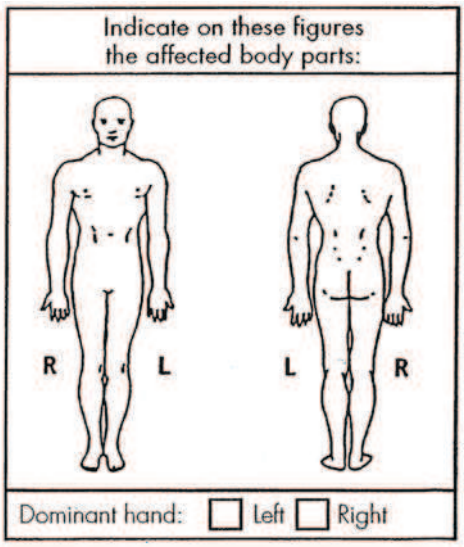
Specific area where incident occurred _____

Describe and Illustrate(at right) your injury _____

Describe the incident _____

Name of Witness to incident(print) _____

Employee Signature _____ Date _____



SUPERVISOR INITIAL REPORT

Supervisor Name _____

Was there a specific incident/accident? ☐Yes ☐No ☐Unknown Did you witness the incident/accident? ☐Yes ☐No

Give a step by step description of what you understand to have happened _____

Substance/object directly causing injury _____

Was employee sent to hospital or physician? ☐Yes Date / / ☐No If yes, where: _____

Did employee return to work same day? ☐Yes ☐No Was injury lost time? ☐Yes ☐No First full day out of work: / /

Sent home remainder of shift? ☐ Yes ☐ No Light Duty available? ☐ Yes ☐ No

Supervisor's Signature: _____

EMPLOYEE AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

Instructions: This form is to be completed by the employee and submitted with the Initial Injury Report

FOR: Last Name _____ First Name _____ MI _____

Social Security No. _____

INJURY DATE: _____

The above individual has made a claim for a job-related injury. The information requested will be used for the sole purpose of administering this claim.

This is to authorize the release, use or disclosure of any and all medical information or opinions regarding my physical and psychological condition and treatment for this injury by my physician, hospital, medical attendant or others involved in my care to the Town of Westerly and its designee, Beacon Mutual Insurance Co. for employment-related purposes beyond treatment, payment, or health care operations as provided by the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that I may revoke this Authorization at any time by providing written notification to the Town of Westerly Town Manager with the understanding that revocation may affect my Injured on Duty status. I understand that the information used or disclosed pursuant to this Authorization my be subject to redisclosure by the named recipient, and may no longer be protected by HIPAA's privacy rules after the authorized disclosure.

Employee Signature: _____

Date: _____