TOWN OF WELLESLEY
WORK RELATED INCIDENT REPORT
and
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To be filled out by Employee/Supervisor, signed by Employee and Supervisor, and submitted immediately after incident.

Employee Name		Dept/Division	Last 4 digits of SSN
Full Address			Telephone Number
Job Title		Date of Birth	Marital status (M or S)
Date of incident	Time of incident	Location of incident	
Date incident reported	To whom was incident reported? (name & job title)		Witness (name & job title)
Source of injury (tool, machine)		Type of injury	Body part(s)

Medical care required? Yes_____ No_____
If yes, name and address of medical care provider:

Describe what happened:

_____	_____	_____	_____
Employee signature	Date	Supervisor signature	Date

AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION

I hereby authorize any hospital or other medical provider to release to the Town of Wellesley and/or its agents for worker's compensation insurance purposes, any and all information relative to my work related incident reported above. You are authorized to provide this information in accordance with the Massachusetts workers' compensation law. A photocopy of this authorization should be regarded as a valid release of the information.

Employee signature_____ Date_____

Print name: _____

Address:_____

Please return completed form **with employee signature IMMEDIATELY** to:
Jen Glover, Workers Comp Coordinator, Town Hall, HR Department. jglover@wellesleyma.gov
P: 781.431.1019 x2236 F: 781.431.8643