



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	Time began work	Location of incident (specific building or school)	
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
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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