Human Resources
Town of Reading
16 Lowell Street
Reading, MA 01867

(781) 942-9033 (Office)
(781) 439-6018 (Fax)
www.readingma.gov

M E M O R A N D U M

To: Town of Reading Employees
From: Sean D. Donahue, Human Resources Director
Date: October 17, 2024
Re: Injury reports and Forms

Reporting an accident or injury to the Town of Reading has a number of components and requires fast turn-around in order to facilitate claims management, accident investigation, and more. Additionally, we want to capture information to help prevent similar accidents and injuries to employees across the town.

Accidents or injuries should be reported to Human Resources by the close of business on the day the accident/injury occurred or as soon as feasible, not to exceed 48 hours. Any school-related injuries should be reported to Central Office Human Resources.

1. Anyone injured should report to their supervisor immediately. Call 911 for any life-threatening injuries. Any injuries requiring treatment should otherwise immediately be referred to our occupational health provider, Quadrant Health Strategies, 500 Cummings Place, Beverly, MA (978) 532-2428.
2. Supervisors complete the Supervisor's Report of Accident – Intake Form.
3. The injured employee must fill out a Medical Authorization (not below the signature line) and sign and date it.
4. Any witnesses may include a Witness Statement. (Word document, email, written, etc.)
5. The supervisor or reporting authority (i.e. a School Nurse) should assemble all the forms, scan, and submit electronically to Avantika Mehta, Benefits Specialist, amehta@readingma.gov by the close of business the day first notified. Please do not send via Interoffice Mail due to security/privacy concerns.
6. Any employee who does not return to work the day after an injury should notify Human Resources immediately.
7. Any employee that returns to work after a work-related injury absence please contact Human Resources with clearance from a doctor before returning to work.

Note: These forms and protocols are subject to change.

Please feel free to email me with any questions at sdonahue@readingma.gov.

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Town of Reading

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☐ WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM YES☐ NO☐
WAS THE EMPLOYEE HOSPITALIZED OVERNIGHT AS AN INPATIENT YES☐ NO☐
NAME OF PHYSICIAN OR HEALTHCARE PROFESSIONAL: _____
MEDICAL FACILITY NAME:_____ADDRESS _____CITY_____STATE__ ZIP_____
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**

Cause	Body Part	Nature	Occupation/Job Code
STRUCK AGAINST	ABDOMEN	INSECT BITE	ADMIN ASSISTANT
STRUCK BY	ANKLE	AMPUTATION	ADMINISTRATION
FALL DIFF LEVEL	ARM	ASPHYXIATION	ANIMAL CONTROL
FALL SAME LEV.	BACK	ANIMAL BITE	CARPENTER
CAUGHT BETWEEN	BOD PTS, NEC	BURN/SCALD	CLERICAL
HOLDING PNT UP	BODY SYSTEM	CARPAL TUNNEL	CONSERV. AGENT
LIFTING	BRAIN	BURN(CHEMICAL)	COOK
LIFT OBJ LOWER	BUTTOCKS	CONCUSSION	DRIVERS NOC
CARRYING	CHEST/RIBS	INFECT. DISEASE	ELECTRICIAN
BENDING/REACH	DIGEST SYS	CONTUSION	EMT
WHEELCHAIR	EAR	CUT/PUNCTURE	EQUIP/OPERATORS
FALL ON STAIRS	ELBOW	SPLINTER	FOREMAN
FALL OUTSIDE PR	EXCRET SYS	DERMATITIS	GENERAL ADMIN
STRUCK BY DOOR	EYES	POISON IVY	GROUNDSKEEPER
HANDTOOLS	FINGER	DISLOCATION	HARBORMASTER
POWER HAND TOOL	FOOT	ELECTRIC SHOCK	HEALTH PROF
RUB/ABRADE	GROIN	FRACTURE	INSPECTOR
SPLASHING LIQ	HAND	FROSTBITE	LABORERS
FOREIGN BDY EYE	HEAD	HEARING LOSS	LIBRARIAN
STEP ON OBJ.	HEART	VISION LOSS	LIFEGUARD
CUTS/NOT NEEDLE	HEEL	HEAT EXHAUSTION	LINEHAUL (ROAD)
PUNCH NDLE DISC	HIP	HERNIA	LINEMAN
PUNCH NDLE USE	JAW	HUMAN BITES	LPN
COLL /PERSON	KNEE	HUMAN SCRATCHES	MAINTENANCE WKR
STRUCK BY PNT	LEG	INFLAM MUSCLES	MARINE WORKER
OCCUP DISEASE	LO EXTR	POISONING	MASON/PLASTERER
EXPL & FIRE	LO EXTR MULT	PNEUMOCONIOS	MECHANIC
COMM.DISEASE	LO EXTR,NEC	SUNBURN	METER READER
BODY REACTION	LOWER LEG	SPRAIN	MISC NOC
ANIMAL BITE	MOUTH	STRAINS	PAINTER
OVEREXER/STRESS	MULTIPLE PTS	ULCERATIONS	PLANT OPERATOR
ELECTRIC SHOCK	MUS/SKEL SYS	VARICOSITIES	PLUMBER
TEMP. EXTREME	NECK	HEMORRHOIDS	REFUSE COLLECT
CONTACT TOXIC	NERV SYS/STRESS	MULT.INJURIES	REFUSE DRIVER
ASSAULT	NOSE	FOREIGN BODY	SCH/BUS/DRIVER
INSECT BITE	OTH BOD SYS	MENTAL DISORDER	SCH/CAFETERIA
MOTOR VEH ACC.	PELVIS	NERV SYS/STRESS	SCH/CUSTODIAN
TRIPPED/TURNED	RESP SYS	RESP. SYSTEM	SCH/NURSE
CLIMBING	SCALP	EYE IRRITATION	SCHOOL TEACHER
PULLING HOSE	SHOULDER	PROTH DEVICE	SCHOOL/AIDE
CONTAGIOU PLANT	SKIN	OCC. DISEASE	SCHOOL/CLERICAL
SHOT	TEETH	HEART ATTACK	SCHOOL/CROSSING
HLD-UP RIOT	THIGH	HYPERTEN/STROKE	SECRETARY
ROBBERY	TOES	FAINTING	SUPERINTENDENT
HORSEPLAY/FIGHT	TRUNK	SCARRING	TEMP/OTHER
WINDBLOWN OBJ.	TRUNK MULTI	cardio/vascular	TEMP/SUMMER
REPETITIVE MOT.	UP EXTR	NOT CLASSIFIED	TREE WORKER

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Member Services
Aon, MSC 17668, P.O. Box 549294,
Waltham, Massachusetts 02454
Toll Free (Mass) :888/266-6442
Fax: 617 753-9987

MEDICAL AUTHORIZATION

To: _____ Date:_____

_____

_____

and any other physician, hospital, clinic or medical care provider, presently unknown to me, who may have or subsequently acquire information concerning my physical condition. You are hereby authorized to give MIIA Member Services and/or any of its representatives, all information, facts and particulars, including reports, records, results from diagnostic tests, X-rays and statements of charges which may be requested regarding my medical condition, diagnosis, treatment and to furnish them copies of such reports. You are further authorized to allow any physicians appointed by them to review all such reports, records and X-rays in your possession.

I am willing that a photo static copy of this authorization be accepted with the same authority as the original.

This information is to be used for handling my claim from an occupational injury or illness occurring on or about _____ and for no other purpose, now or in the future.

This authorization is valid for the duration of the above condition.

_____ _____
(Employee's signature) (Date)

Employer: _____
Name of Employee:_____
SS#: _____ Date of Birth: _____
Claim #:_____ Date of Accident: _____