**CITY OF HAVERHILL**

**FORM 118 - EMPLOYER’S NOTIFICATION TO INSURER OF MEDICAL ONLY INJURIES**

(If an injury has resulted in 5 or more lost work days, File “Employer’s First Report of Injury” – Form 101)

PLEASE PRINT OR TYPE:

|  |  |  |
| --- | --- | --- |
| 1. Employee Name (Last, First, MI) | 2. Home Telephone | 3. Social Security Number  |
|  |  **(****)**  |  |
| 4. Home Address (No. & Street, City, State, Zip Code) | 5. Marital Status | 6. No. of Dependents |
|  | **[ ] Single****[ ] Married** |  |
| 7. Date of Hire (MM/DD/YY): | 8. Date of Birth (MM/DD/YY): | 9. Sex | 10. Hourly Wage |
|  |  | **[ ] Male** **[ ] Female** **[ ] Non-Binary** |  |
| 11. Worker | 12. Hours Worked Per day | 13. Days Worked Per Week | 14. Avg. 52-Week Wage $      |
| **[ ]  Salary** **[ ]  Hourly** |  |  | **[ ] Estimated** **[ ] Actual** |
| 15. Employer Name | 16. Employer Self-Insured? | 17. Federal Tax ID |
|  CITY OF HAVERHILL DEPARTMENT:  |  [x] YES [ ] NO | 04-6001392 |
| 18. Employer Address (No. & Street, City, State, Zip Code) | 19. Employer Telephone | 20. Industry Code  |
|  4 Summer Street Room 306 Haverhill, MA 01830 | (978) 374-2357 | N/A |
| 21. Insurance Carrier: Name and address of Branch responsible for this case (Not Local Agent or Adjuster)CITY OF HAVERHILL4 Summer Street Room #306Haverhill, MA 01830ATTN: Human Resources  |
| 22. Worker’s Compensation Policy NumberN/A | 23. OSHA Case File Number (if applicable)N/A |

|  |  |  |
| --- | --- | --- |
| 24. Date of Injury (MM/DD/YY) | 25. Time of Injury | 26. Source of Injury (e.g., Machine, Tool, Substance, etc.) |
|  | **[ ] A.M.** **[ ]  P.M.** |  |
| 27. Address Where Injury Occurred (if different from #18 above) | 28. On Employer’s Premises? | 29. Employer Location Code |
|  | **[ ]  YES** **[ ]  NO** | **N/A** |
| 30. Regular Occupation | 31. Regular Occupation When Injured? |
|  | **[ ]  YES** **[ ]  NO** |
| 32. To Whom Was Injury Reported? | 33. Date Reported (MM/DD/YY): |
|  |  |
| 34. Nature of Injury: (Burn, Fracture, Cut, Bruise, etc.) | 35. Injured Body part(s) Description (Arm, Leg, Back, Right/Left Etc.) |
| 36. Describe How Injury Occurred in **DETAIL** (e.g., Struck by\_\_\_, Fell from \_\_\_, Exposed to \_\_\_...) |
|  |
| 37.Please select applicable visit type**[ ]** Walk-In [ ]  Emergency Room visit [ ]  Primary Care Doctor visit [ ]  Did not seek medical  Hospital Name: Doctors Name attention . Address Address  City State ZIP City, State ZIP |
| 38. If Employee Has Returned to Work,  | 39. Returned to Regular Duties? 40. Returned to Modified Duties? |
|  **Date of return**:  | **[ ] YES Date: [ ] YES Date:****[ ]  NO [ ]  NO** |
| 41. Preparer’s Name (Please Print or Type) | 42. Preparer’s Title |
|   |  |
| 43. Preparer’s Signature | 44. Date Prepared (MM/DD/YY): |
|        |  |

HR OFFICE USE ONLY

WC Claim #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Entered by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

THIS FORM WHEN COMPLETED SHOULD BE SENT TO CITY HALL, ROOM 306, 4 SUMMER STREET, HAVERHILL, MA OR EMAILED TO HRD@HAVERHILLMA.GOV.

**MEDICAL AUTHORIZATION FORM**

Employee:

Claim #:

DATE:

TO:

and any other physicians, hospitals, 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 to , or any of its representatives, all information, facts and particulars, including reports, results from diagnostic tests, x-rays and statements of charges which may be requested regarding my medical condition, diagnosis, treatment rendered, prognosis, estimates of disability or recommendations for further treatments and to furnish them copies of such reports. You are further authorized to allow any physician appointed by them to review all such reports, records and x-rays in your possession.

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

“This information is to be used for the purposes of evaluating and handling my injury, and for no other purpose, now or in the future.”

**THIS AUTHORIZATION EXPIRES ON CONCLUSION OF THE CLAIM**

EMPLOYEE SIGNATURE: