TOWN OF PEMBROKE
EMPLOYEE REPORT OF INCIDENT

Form must be emailed or faxed upon completion within 24 hours of incident to Sabrina in the BOS Office at schilcott@townofpembrokemass.org fax (781) 293-4650.

Employee Name (First, Last):		**Telephone:**
Address (Including ZIP):	**DOB:**	**Marital Status:**
	SSN:	**Gender: Please Check One** **Male _____ Female _____**
Dept.:	**Position:**	**Supervisor & Contact Number:**
Full or Part Time:	**Date & Time of Injury:**	**Date Injury Reported and to Whom:**
Address Where Injury Occurred:		**Witness & Contact Number:**
Body Part Injury:	**Source of Injury (Fall, Pulling, Trip, etc.):**	**Was Medical Treatment Sought?**
Type of Injury (Bruise, Cut, etc.):	**Clinic or Hospital Name & Address:**	
Describe How Injury Occurred:		
Was there any lost time from work due to the injury? Yes_____ No_____ Number of Days Lost:_____		
Expected Return to Work Date:		
Federal ID: 04-600-1264	**Employer: Town of Pembroke**	**Claim Number:**
Employer Address: 100 Center Street Pembroke, MA 02359		**Phone: 781-293-3844**
Employee Signature:		**Date:**
Employer's Signature:		**Date:**

Forward this original form to Sabrina Chilcott for submittal and retention; employee keeps a copy for their records. **Please call 781-709-1402 if you have any questions or need assistance.**

Worker's Compensation Administration Information: Guardian Claims Services, LLC
68 Evergreen Street, Suite 12, PO Box (B) Kingston, MA 02364
Telephone: (508) 342-1688 Fax: (508) 342-1689

Please See Reverse Side for Additional Required Signature

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit in an insurance claim application may be guilty of a crime and may be subject to fines and/or imprisonment.

MEDICAL AUTHORIZATION

EMPLOYEE:_____

CLAIM #:_____

TO:_____ **DATE:**_____

_____

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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 **Guardian Claims Services, LLC**, 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 rendered, prognosis, estimates of disability or recommendations for further treatment 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 purposes of evaluating and handling my workers' compensation injury, and for no other purpose, now or in the future.

THIS AUTHORIZATION EXPIRES ON CONCLUSION OF CLAIM.

SIGNATURE:_____