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.

<table>
<tr><td colspan="2">Employee Name (First, Last):</td><td>Telephone:</td></tr>
<tr><td rowspan="2">Address (Including ZIP):</td><td>DOB:</td><td>Marital Status:</td></tr>
<tr><td>SSN:</td><td>Gender: Please Check One
Male ________ Female ________</td></tr>
<tr><td>Dept.:</td><td>Position:</td><td>Supervisor & Contact Number:</td></tr>
<tr><td>Full or Part Time:</td><td>Date & Time of Injury:</td><td>Date Injury Reported and to Whom:</td></tr>
<tr><td colspan="2">Address Where Injury Occurred:</td><td>Witness & Contact Number:</td></tr>
<tr><td>Body Part Injury:</td><td>Source of Injury (Fall, Pulling, Trip, etc.):</td><td>Was Medical Treatment Sought?</td></tr>
<tr><td colspan="2">Type of Injury (Bruise, Cut, etc.):</td><td>Clinic or Hospital Name & Address:</td></tr>
<tr><td colspan="3">Describe How Injury Occurred:</td></tr>
<tr><td colspan="3">Was there any lost time from work due to the injury? Yes______ No______ Number of Days Lost:_________</td></tr>
<tr><td colspan="3">Expected Return to Work Date:</td></tr>
<tr><td>Federal ID: 04-600-1264</td><td>Employer: Town of Pembroke</td><td>Claim Number: 00433</td></tr>
<tr><td colspan="2">Employer Address: 100 Center Street Pembroke, MA 02359</td><td>Phone: 781-293-3844</td></tr>
<tr><td colspan="2">Employee Signature:</td><td>Date:</td></tr>
<tr><td colspan="2">Employer's Signature:</td><td>Date:</td></tr>
</table>

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: Cook & Company Insurance Services, Inc., 1025 Plain Street, PO Box 1068, Marshfield, MA 02050

Telephone: (781) 837-7300 Fax: (781) 837-8986

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.

Cook & Company Insurance Services, Inc.
1025 Plain Street
P.O. Box 1068
Marshfield, MA 02050
Tel: 781-837-7300
Fax: 781-837-8986

AUTHORIZATION TO RELEASE MEDICAL INFORMATION WORKERS' COMPENSATION

Date:	Cook Claim Number: (leave blank if unknown)
Employer:	
Claimant/Employee Full Name:	
Date of Injury:	

To: Health Care Provider 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 related specifically to an incident that occurred on the above date of injury and for which application for IOD has been made.

You are hereby authorized to give COOK & COMPANY INSURANCE SERVICES, INC. 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 authorize a facsimile or photocopy of this document can be accepted with the same authority as the original.

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

THIS AUTHORIZATION EXPIRES ON CONCLUSION OF CLAIM.

Claimant/Employee Signature: ______________________________