



25 New Chardon St • Boston, MA 02114-4721 • Phone: (617) 488-6500 • Fax: (617) 488-6502

**EMPLOYEE INCIDENT REPORT**  
**This Report Must Be Sent To Administration Within 24 Hours of Incident**

**File Only &  
First Aid < \$750.00**

**Medical Only  
(Less than 4 Days of Disability)  
Also complete form 8WC**

**Lost Time  
(4 or More Disability Days)  
Also complete Forms 8WC & 13WCA**

**EMPLOYER'S NAME:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**I. SUPERVISORY REPORT**

|   |  |                       |  |                              |  |                            |  |
|---|--|-----------------------|--|------------------------------|--|----------------------------|--|
| Name of Employee                                |  | Job Title             |  | Date of Birth                |  | Social Security Number     |  |
| Home Address                                    |  |                       |  | Home Phone Number<br>( ) ( ) |  |                            |  |
| Date of Incident                                |  | Time ( ) AM<br>( ) PM |  | Department/Shift             |  | Date of Hire               |  |
| Location of Incident                            |  |                       |  |                              |  |                            |  |
| Who was first notified of Incident?             |  |                       |  | Date & Time                  |  |                            |  |
| Name of Witness(es)                             |  |                       |  |                              |  |                            |  |
| Did Employee Require Medical Attention?         |  | Yes ( )               |  | No ( )                       |  | Date of Initial Treatment: |  |
| If yes: Physician or Hospital Name and Address: |  |                       |  |                              |  |                            |  |
| Any Lost-Time from Work?                        |  | Yes ( )               |  | No ( )                       |  | Actual Dates:              |  |
| Has Employee returned to Work?                  |  | Yes ( )               |  | No ( )                       |  | Date:                      |  |
| Name of Person Preparing Report:                |  |                       |  | Title:                       |  |                            |  |
| Signature:                                      |  |                       |  | Date:                        |  |                            |  |

**II. EMPLOYEE'S STATEMENT**

Describe the Incident in Detail:

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Part of Body Injured (Be Specific: Right or Left, etc.):

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**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**III. > EMPLOYEE'S MEDICAL AUTHORIZATION < (REQUIRED)**

I authorize the release of all medical information without limitation, including, but not limited to, history, findings, diagnosis, prognosis and access to all treatment records for examination and photocopying to Charter Management Company, Inc., Atlantic Charter Insurance Company and Sallop and Weisman P.C. I authorize that a photocopy of this form be accepted with the same authority as the original. Please be advised that pursuant to 45 CFR 164.512(l), the HIPAA Privacy Rule does not apply to entities that are either workers' compensation insurers, workers' compensation administrative agencies or employers. The Privacy Rule recognizes the legitimate need of insurers and other entities involved in the workers' compensation system to have access to an individual's health information as authorized by state or other law.

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_