MIIA Massachusetts Based Member Driven

EMPLOYEE'S STATEMENT OF INJURY FACTS

Employee Name:_____ Employee Address:_____
Telephone:Home:_____Work:_____Date of Birth:_____
Social Security #:_____ Sex(M or F):_____ Marital Status:_____
Number of Dependents: (Give Name, Relationship, Date of Birth)_____
_____
Employer's Name:_____ Occupation:_____
How Long Worked for Employer?_____
Date of Injury:_____Time of Injury:_____
To Whom Was Injury Reported To/Their Position?_____
Fully describe what you were doing & how the injury occurred:_____
_____
_____
_____
Nature & location of injury: (Describe fully, given part of body, right/left, etc.)_____
_____
Witness: (If none, state so) _____
Did Employee Lose Time From Work? Yes ☐ No☐ First Day of Lost Time:_____
Return To Work Date:_____
Was Medical Treatment Sought? Yes ☐ No☐
If "Yes", give name of Doctor or Medical facility:_____
Do you have other concurrent employment? Yes☐ No☐
If "Yes", give name & address of company:_____
Have you worked anywhere since your first day of Lost Time? Yes☐ No☐
If "yes", explain:_____
Have you ever had a Work Related Injury? Yes☐ No☐
If "yes", give details:_____
_____
Do you have any pre-existing condition which restricts you in any way from performing your regular job duties with or without job modification? Yes☐ No☐
If "yes", give details: _____
_____
_____
Remarks & Comments (use reverse side if needed):_____
_____
_____
_____

I have read the above questions and answered each to the best of my ability. My responses are true and correct to the best of my knowledge. I have retained a copy of this statement for my records.

_____ _____ _____
(Employee Signature) (Witness Signature) (Date of Report)

Return Original to:
MIIA Member Services
c/o Aon Risk Solutions
One Federal Street
Boston, MA 02110

Retain a copy for your records