Town of Merrimac – Worker's Compensation

Reporting and Handling Work Related Injuries

- The injured worker should receive prompt and appropriate medical attention, preferably from someone in an Occupational Health Center.
- The injured worker must report the incident to the supervisor as soon as possible.

- The supervisor must complete the "Supervisor's Report of Accident-Intake Form", obtain a signed "Authorization to Release Medical Information", and forward it to the Member Injury Coordinator or his/her alternate before day's end. The employee must take the MyMatrix Pharmacy Form with them. The Town of Merrimac has designated Carol McLeod as the Member Injury Coordinator, and if she is unavailable, Jennifer Penney is the alternate.

- The Member Injury Coordinator must notify MIIA Member Services immediately by entering the forms on the MIIA Worker's Compensation Risk Console.

It is the Employer's responsibility (not the employee's) to report all potential work related injuries to MIIA Member Services.

- The Member Injury Coordinator can work with the designated Occupational Health Center to determine if a modified duty position is available within the restrictions provided.

- If there is lost time, fax the wage history information.

- The injured worker must complete and submit a "Notice of Injury" Form to the Essex Regional Retirement Board within 90 days of injury.

Merrimac, Town of

SUPERVISOR'S REPORT OF ACCIDENT- INTAKE FORM

DATE OF INJURY:______TIME OF INJURY________ ACKNOWLEDGE/DATE REPORTED_________

DESCRIPTION OF ACCIDENT; WHAT WAS EMPLOYEE DOING? WHAT HAPPENED?WHY?____

____

*CAUSE:_______________*NATURE:_________________ *BODY PART:____________*OCCUPATION______________

EMPLOYEE NAME______________________ SOCIAL SECURITY #________________
SEX(M or F)______ MARITAL STATUS_________ DATE OF BIRTH________________
DATE OF HIRE______________ DEPARTMENT______________________________
SUPERVISOR NAME _____________________ PHONE NUMBER________________

EMPLOYEE ADDRESS____
TELEPHONE NUMBER: HOME__________________WORK___________________
CELL______________________ EMAIL____

LOCATION ACCIDENT OCCURRED_______________________(Include Building or School Name)
INJURED ON PREMISE YES☐ NO ☐
AVERAGE WEEKLY WAGE_____________
DID EMPLOYEE LOSE TIME FROM WORK? YES☐ NO☐
NUMBER OF DEPENDENTS__________
DID EMPLOYEE RETURN TO WORK YES☐ NO☐
IF YES, DATE RETURN TO WORK:________ Full Duty YES☐ NO☐ Modified Duty YES☐ NO☐
TIME BEGAN WORK__________
IF NO, LAST DAY WORK_______1ST DAY OF DISABILITY_______5TH DAY OF DISABILITY_____ (calendar days)

WAS MEDICAL TREATMENT SOUGHT? YES☐ NO☐
MEDICAL FACILITY ____

DATE REPORTED AS WORK RELATED:______________
WITNESS ____________________________
TO WHOM WAS INJURY REPORTED TO ____________________________

*********Supervisor's Complete Below***********

CAUSE-UNSAFE ACT OR CONDITION; OBJECT/SUBSTANCE CAUSING INJURY

____

____

WAS EMPLOYEE WEARING SAFETY GEAR? YES☐ NO ☐ IF NO, EXPLAIN)____

ACTION TAKEN TO PREVENT SIMILAR ACCIDENTS____

____

REMARKS____

____

Investigated By________________________________ Date_____________

Reviewed By__________________________________ Date_____________

☐ School Nurse ☐ Supervisor

***See page 2 for selection listing**
Red Font: New OSHA Require data
2/1/19

Cause	Body Part	Nature	Occupation/Job Code
STRUCK AGAINST	ABDOMEN	INSECT BITE	ADMIN ASSISTANT
STRUCK BY	ANKLE	AMPUTATION	ADMINISTRATION
FALL DIFF LEVEL	ARM	ASPHYXIATION	ANIMAL CONTROL
FALL SAME LEV.	BACK	ANIMAL BITE	CARPENTER
CAUGHT BETWEEN	BOD PTS, NEC	BURN/SCALD	CLERICAL
HOLDING PNT UP	BODY SYSTEM	CARPAL TUNNEL	CONSERV. AGENT
LIFTING	BRAIN	BURN(CHEMICAL)	COOK
LIFT OBJ LOWER	BUTTOCKS	CONCUSSION	DRIVERS NOC
CARRYING	CHEST/RIBS	INFECT. DISEASE	ELECTRICIAN
BENDING/REACH	DIGEST SYS	CONTUSION	EMT
WHEELCHAIR	EAR	CUT/PUNCTURE	EQUIP/OPERATORS
FALL ON STAIRS	ELBOW	SPLINTER	FOREMAN
FALL OUTSIDE PR	EXCRET SYS	DERMATITIS	GENERAL ADMIN
STRUCK BY DOOR	EYES	POISON IVY	GROUNDSKEEPER
HANDTOOLS	FINGER	DISLOCATION	HARBORMASTER
POWER HAND TOOL	FOOT	ELECTRIC SHOCK	HEALTH PROF
RUB/ABRADE	GROIN	FRACTURE	INSPECTOR
SPLASHING LIQ	HAND	FROSTBITE	LABORERS
FOREIGN BDY EYE	HEAD	HEARING LOSS	LIBRARIAN
STEP ON OBJ.	HEART	VISION LOSS	LIFEGUARD
CUTS/NOT NEEDLE	HEEL	HEAT EXHAUSTION	LINEHAUL (ROAD)
PUNCH NDLE DISC	HIP	HERNIA	LINEMAN
PUNCH NDLE USE	JAW	HUMAN BITES	LPN
COLL /PERSON	KNEE	HUMAN SCRATCHES	MAINTENANCE WKR
STRUCK BY PNT	LEG	INFLAM MUSCLES	MARINE WORKER
OCCUP DISEASE	LO EXTR	POISONING	MASON/PLASTERER
EXPL & FIRE	LO EXTR MULT	PNEUMOCONIOS	MECHANIC
COMM.DISEASE	LO EXTR,NEC	SUNBURN	METER READER
BODY REACTION	LOWER LEG	SPRAIN	MISC NOC
ANIMAL BITE	MOUTH	STRAINS	PAINTER
OVEREXER/STRESS	MULTIPLE PTS	ULCERATIONS	PLANT OPERATOR
ELECTRIC SHOCK	MUS/SKEL SYS	VARICOSITIES	PLUMBER
TEMP. EXTREME	NECK	HEMORRHOIDS	REFUSE COLLECT
CONTACT TOXIC	NERV SYS/STRESS	MULT.INJURIES	REFUSE DRIVER
ASSAULT	NOSE	FOREIGN BODY	SCH/BUS/DRIVER
INSECT BITE	OTH BOD SYS	MENTAL DISORDER	SCH/CAFETERIA
MOTOR VEH ACC.	PELVIS	NERV SYS/STRESS	SCH/CUSTODIAN
TRIPPED/TURNED	RESP SYS	RESP. SYSTEM	SCH/NURSE
CLIMBING	SCALP	EYE IRRITATION	SCHOOL TEACHER
PULLING HOSE	SHOULDER	PROTH DEVICE	SCHOOL/AIDE
CONTAGIOU PLANT	SKIN	OCC. DISEASE	SCHOOL/CLERICAL
SHOT	TEETH	HEART ATTACK	SCHOOL/CROSSING
HLD-UP RIOT	THIGH	HYPERTEN/STROKE	SECRETARY
ROBBERY	TOES	FAINTING	SUPERINTENDENT
HORSEPLAY/FIGHT	TRUNK	SCARRING	TEMP/OTHER
WINDBLOWN OBJ.	TRUNK MULTI	cardio/vascular	TEMP/SUMMER
REPETITIVE MOT.	UP EXTR	NOT CLASSIFIED	TREE WORKER

Member Services
53 State Street, Boston Massachusetts 02109
Toll Free (Mass) :888/266-6442
Fax: 617 753-9987

MEDICAL AUTHORIZATION

To: Date

And any other physician, hospital, 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 MIIA Member Services and/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 and to furnish them copies of such reports. You are further authorized to allow any physicians appointed by them to review all such reports, records and X-rays in your possession.

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

This information is to be used for handling my claim from an occupational injury or illness occurring on ____________ and for no other purpose, now or in the future.

This authorization is valid for the duration of the above condition.

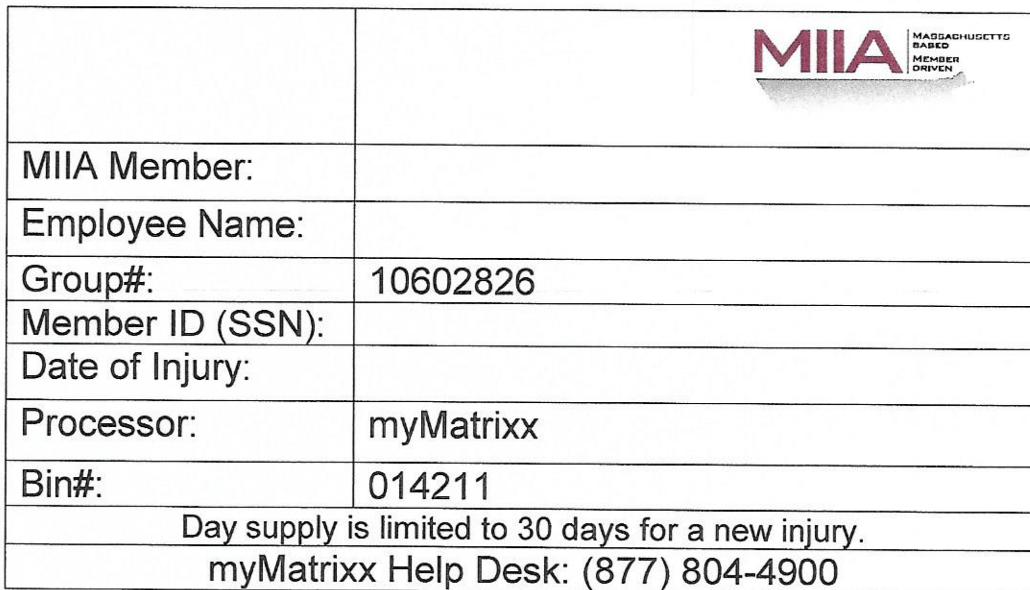
__________________________ __________________________
(Employee's signature) (Date)

Employer:
Name of Employee:
Date of Birth:
Claim #:

myMatrixx
good medicine for business

MIIA Members Services
Workers' Compensation Prescription Information

Employer:
Please fill out employee information below and provide employee with this document to take to any pharmacy with prescriptions.



	MIIA MASSACHUSETTS BASED MEMBER DRIVEN
MIIA Member:	
Employee Name:	
Group#:	10602826
Member ID (SSN):	
Date of Injury:	
Processor:	myMatrixx
Bin#:	014211
Day supply is limited to 30 days for a new injury.	
myMatrixx Help Desk: (877) 804-4900	

Employee:
MIIA Members Services has partnered with ***myMatrixx*** to make filling workers' compensation prescriptions easy.

This document serves as a temporary prescription card. A permanent prescription card specific to your injury will be forwarded directly to you within the next 3 to 5 business days.

Please take this letter and your prescription(s) to a pharmacy near you. myMatrixx has a network of over 64,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call myMatrixx toll free at (877) 804-4900.

IF YOU ARE DENIED MEDICATION(S) AT THE PHARMACY PLEASE CALL (877) 804-4900

Pharmacist:
Please obtain above information from the injured employee if not already filled in by employer to process prescriptions for the workers' compensation injury only.

For questions or rejections please call (877) 804-4900. Please do not send patient home or have patient pay for medication(s) before calling myMatrixx for assistance.

NOTE: Certain medications are pre-approved for this patient; these medications will process without an authorization. All others will require prior approval.

FOR ALL REJECTIONS OR QUESTIONS CALL: (877) 804-4900

NOTE – This form should be filed with the Retirement Board by the member or in his behalf WITHIN NINETY DAYS from the date of accident or hazard undergone.

The Commonwealth of Massachusetts

ESSEX REGIONAL RETIREMENT SYSTEM

DANVERS, MA 01923

NOTICE OF INJURY

TO THE BOARD OF RETIREMENT:

This is to notify you that ……………………………………………………….…received injuries incurred through
(Full Name of Employee)
accident in the line of duty or due to a hazard which occurred in the like line of duty while employed in the service at the

…………………………………….………..………… on …………………….……….………… and whose home address is
(Name of Department or Institution) (Month) (Day) (Year)

……
(Street and Number) (City or Town) (Zip)

1. **Single……… Married………… 1a. If married, spouse's name……………………………………………………………..**
2. **Date of Birth…………………………………………2a. Date of Entry in Service ………………………………………….**
3. **Rate of regular compensation on the date of the accident ……………………………….…per ……………………………..**
4. **The cause of injury was……………………………………………………………………………………………………**
   Describe Cause of Injury

……….………
(If statement requires more space use other side of this blank and write in this space – SEE OTHER SIDE)
……
(Important: Sign your name after what you write on the other side)
……

5. **The nature of injury is as follows:…………………………………………………………………………………………...**
   (Describe Injury with as much exactness as possible)

……

……

IMPORTANT: # 6, 7& 8 must not be left blank. Some statement must be made. –Example—Not taken to a hospital, No witness, etc.

6. **NAME AND ADDRESS OF DOCTOR WHO ATTENDED EMPLOYEE ……………………………………………………...**

   Address ……
   (Street and Number) (City)) (State) (Zip)

7. **NAME AND ADDRESS OF HOSPITAL …………………………………………………………………………………………**

   Address………
   (Street and Number) (City)) (State) (Zip)

8. **NAME AND ADDRESS OF WITNESS (If possible, give 2 named of eye witnesses)**

   1. **Name………………………………………………….Address No. ………………………..…………………………….Street**

      City or Town…………………………………………… State ………………………………..………………..Zip…………………

   2. **Name………………………………………………….Address No. ………………………………………………..….Street**

      City or Town…………………………………………… State ……………………………………..……………..Zip…………………

IMPORTANT: # 6, 7& 8 must not be left blank. Some statement must be made. –Example—Not taken to a hospital, No witness, etc.

SIGNATURE………………………………………………………….. **Date…………………………………….**
(If other informant, relationship or title of superior officer)

IMPORTANT

The Law requires that injuries incurred in the line of duty AFTER JULY 1, 1938, shall be reported to the RETIREMENT BOARD WITHIN NINETY DAYS to give unlimited coverage for (1) retirement based upon accidental injuries or (2) an accidental death benefit.

IF the NOTICE OF INJURY is not so filed WITHIN NINETY DAYS an APPLICATION for (1) accidental disability retirement or (2) for a death benefit based upon accidental injuries incurred MORE THAN TWO YEARS PRIOR to the date of application, IS VOID.