City of Gardner
Human Resources Department
95 Pleasant Street, Rm. 14
Gardner, MA 01440
(978) 630-4001 • Fax (978) 630-4025

RESPONSIBILITIES WHEN AN EMPLOYEE IS INJURED AT WORK:

Responsibilities of the employee when injured at work:

1. THE INJURY MUST BE REPORTED IMMEDIATELY TO THE SUPERVISOR. The employee must fill out their own "ACCIDENT REPORTING AND TREATMENT FORM" and sign it. This form must be completed at the time of the injury regardless of how minor the injury may seem. All questions on the form must be completed (DO NOT SKIP ANY SECTIONS. Research that must be conducted by the Human Resources Department to complete the form will delay entering the claim and the ability to obtain appropriate medical treatment approvals.)

Responsibilities of the Supervisor (Employer) when an employee reports an injury at work:

1. If the employee needs medical treatment, seek such treatment at once.

2. The supervisor is responsible to collect the "ACCIDENT REPORTING AND TREATMENT FORM" from the employee, and send the original to the Human Resources Department at City Hall. This shall be done at the time of the injury.

   At this point, if there is no lost time from work, the above form is all that is needed to be completed and sent to the Human Resources Department. Medical bills regarding this injury that have not been sent directly to MEGA (the Worker's Compensation insurance carrier for the City), should also be sent to the Human Resources Department at City Hall.

   IF THERE ARE FIVE (5) OR MORE DAYS OF DISABILITY, a Department of Industrial Accidents Form 101 MUST ALSO BE FILLED OUT. This will be completed by the Human Resources Department. IT IS EXTREMELY IMPORTANT TO NOTIFY THE HUMAN RESOURCES DEPARTMENT IMMEDIATELY WHEN FIVE (5) OR MORE DAYS OF DISABILITY HAVE OCCURRED, AS A FINE WILL BE LEVIED TO THE CITY OF GARDNER BY THE DEPARTMENT OF INDUSTRIAL ACCIDENTS FOR LATE REPORTING.

   Also, when an employee is losing time from work due to a work injury, it is necessary to complete the Department of Industrial Accident Form 117, the 52 week wage schedule. This form will be completed by the Human Resources Department when notified of a lost time work related injury.

   An employee's compensation rate is based on the average weekly wage of his prior 52 weeks earnings. He/she receives compensation at the rate of 60% of his average weekly wage.

If you have any questions regarding workplace injuries, please contact Debra Pond, Director of Human Resources at (978) 630-4001 or dpond@gardner-ma.gov.

ALL ITEMS/QUESTIONS MUST BE COMPLETED LT MO I

CITY OF GARDNER

ACCIDENT/INCIDENT REPORTING AND TREATMENT FORM

(Non-Public Safety Personnel)

MEGA Location #216

PLEASE COMPLETE ALL SECTIONS

Name of Employee: _____ Social Security # _____-____-_____ Date ____/____/____

Address: _____ City _____ State: _____ Zip: _____

Home Phone: (_____)_____ Work Phone: (____)_____ Date of Birth ____/_____/____

Department: □ School Department (please specify school location):_____
□ Police Department (Dispatcher, Clerical Staff, House worker) □ Greenwood Pool □ Golf
□ City Hall (please specify exact department): _____
□ Council on Aging □ Department of Public Works

Date of Injury _____/_____/_____ Time _____ AM/PM Date of Hire _____/_____/_____

Position Title: _____ Marital Status: ❑ Married ❑ Single

Name of Supervisor:_____ Title: _____

Wage Per Hour: _____ Average Weekly Earnings:_____

No. of Hours Worked Per Day: _____ No. of Days Worked per Week: _____

Scene of Accident/Incident:_____

Witness(es):_____

Describe What Happened, include substances, materials or vehicles involved, including nature of injury and body part affected: _____

_____

Body Part/Injury: _____

Medical Treatment Required: ❑ Yes ❑ No Out of Work: ❑ Yes ❑ No

I hereby authorize The City of Gardner and/or the Massachusetts Education & Government Association – Worker's Compensation Group ("MEGA") (or any of their representatives), to be furnished any information and facts regarding this injury, including reports and records, results of diagnosis, treatment and prognosis, estimates of disability, and recommendations for further treatment. This information is to be used for the purpose of evaluating and handling my claim for injury as a result of the above incident and for no other purpose. A photocopy of this release shall serve and be as valid as the original. This release shall be valid until withdrawn by me in writing.

Signature of Employee_____ Date _____/_____/_____

Please complete Pg. 1 of form and return it to the Human Resources Department. Should you require medical treatment, Pg. 2 of the form should be completed by your medical provider and returned with Pg. 1.

CITY OF GARDNER

OUTSIDE PROVIDER STATEMENT

Name of Employee: _____

Nature of Injury: o New Injury o No injury/illness found o Recurrence/aggravation of existing injury

Type of Injury _____ Body part injured _____

Treatment: _____ Follow up (if any) _____Date ___/____/____

Restrictions:

LIFTING		POSITIONS		PUSHING/PULLING	
No lifting		No work requiring repeated stooping		Pushing or pulling with a	
Lifting with a		No crawling, kneeling or cramped		Limit of 1 – 5 lbs	
Limit of 1 – 5 lbs		Positions		Limit of 6 – 10 lbs	
Limit of 6 – 10 lbs		No continuous walking or standing		Limit of 11 – 25 lbs	
Limit of 11 – 25 lbs		to exceed 50% of total work time		Limit of 25 – 40 lbs	
Limit of 25 – 40 lbs		No continuous sitting		Limit of 41 – 75 lbs	
Limit of 41 – 75 lbs		DEXTERITY		No pushing or pulling	
No reaching ABOVE shoulders		No exposure to vibrating tools		CLIMBING	
No reaching BELOW shoulders		No constant fingering		No work requiring repeated	
		No repetitive wrist motion		or frequent stair climbing	

Other restrictions _____

_____

Patient disposition

o Return to Supervisor; no restrictions

o Return to Supervisor with restrictions (above) for _____days

o Return to Supervisor; send home (employee can return to work _____)

o Follow up appointment on _____with_____

Medical Provider Signature _____Date _____

Printed Name of Medical Provider & Address _____