FORM 160

The Commonwealth of Massachusetts
Department of Industrial Accidents
Lafayette City Center, 2 Avenue de Lafayette, Boston, MA 02111-1750
Info. Line (800) 323-3249 Inside Mass. / (857) 321-7470 Outside Mass.
www.mass.gov/dia

EMPLOYEE BIOGRAPHICAL DATA

PREPARE THIS FORM PRIOR TO A HEARING. THIS FORM IS TO BE GIVEN TO OPPOSING COUNSEL AND MAY BE OFFERED AS EVIDENCE IF SO TESTIFIED.

Employee

Please Print or Type

1. Employee's Name (Last, First, MI):	2. Social Security Number*:	3. Home Telephone No.:	4. Number of Dependents:
5. Home Address (No., Street, City, State & Zip Code):		6. Date of Birth:	
7. Place of Birth:		8. Date U.S. Domicile Established:	
9. Marital Status:	10. Spouses Name:	11. Spouses Occupation:	

12. Names and Ages of Children (attach additional sheet if needed):

1. Age _____ 2. Age_____

3. Age_____ 4. Age_____

5. Age_____ 6. Age_____

Education

13. Name & Address of Last School Attended:	14. Highest Grade Completed and/or Date of Graduation:

15. List any Special Skills or Training Received:

Military Service

16. Branch of Service and Rank:	17. Dates of Service (mm/dd/yyyy):

18. Military Occupation or Specialty:

Work History (begin with most recent employment)

19.

A. Employer: _____ From _____ To _____

Job Description: _____

_____

_____

B. Employer: _____ From _____ To _____

Job Description: _____

_____

_____

*Disclosure of Social Security No. is optional. It will aid in processing forms. (OVER)

Work History - Continued

19.

C. Employer: _____ From - _____ To _____

Job Description: _____

_____

_____

D. Employer: _____ From - _____ To _____

Job Description: _____

_____

_____

E. Employer: _____ From - _____ To _____

Job Description: _____

_____

_____

Medical Data (related to industrial injury)

20. Date of First Medical Treatment (mm/dd/yyyy):	21. Place of First Medical Treatment:

22. Name(s) of Treating Physicians and Dates of Treatments (in Chronological Order):

a. Date _____ b. Date _____

c. Date _____ d. Date _____

e. Date _____ f. Date _____

23. Date(s) and Location(s) of **OUTPATIENT** Hospital Treatment:

_____

_____

_____

24. Date(s) and Location(s) of **INPATIENT** Hospital Treatment:

_____

_____

_____

25. List any Hospital Records and/or Physician reports to be Offered in Evidence by Agreement of Counsel (Please Attach):

_____

_____

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_____

_____

_____