



Workers' Compensation Unit  
One Ashburton Place, 3<sup>rd</sup> Floor  
Boston, MA 02108

## NOTICE OF INJURY/ILLNESS REPORT

**This form is intended for internal use for all Human Resources Division/Workers' Compensation Unit user agencies and must be completed in its entirety. All Notice of Injury Reports must be electronically filed via eServices within 48 hours of an Industrial Accident.**

Soc. Sec. #: \_\_\_\_\_ Date of Injury/Illness: \_\_\_\_\_

Department: \_\_\_\_\_

Department mailing address: \_\_\_\_\_

Name: \_\_\_\_\_  
(First) (Middle) (Last)

Sex: ☐ Male ☐ Female Employee ID#: \_\_\_\_\_ Record#: \_\_\_\_\_

Employee Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Unit: \_\_\_\_\_

Native Language Code: ☐ 1. English ☐ 2. Portuguese ☐ 3. Haitian Creole ☐ 4. Spanish  
☐ 5. Chinese ☐ 6. Vietnamese ☐ 7. Cape Verdean ☐ 9. Other

State Hire Date: \_\_\_\_\_ Department Hire Date: \_\_\_\_\_

Status: ☐ Full Time Employee ☐ Part Time Employee Work Hours/Wk: \_\_\_\_\_

Shift: ☐ 1<sup>st</sup> ☐ 2<sup>nd</sup> ☐ 3<sup>rd</sup> Number of scheduled days off per week: \_\_\_\_\_

Occupation: (Official Position Title) \_\_\_\_\_

Functional Title: \_\_\_\_\_

Payroll Funding Source: ☐ State Payroll ☐ Trust Funded ☐ Federal Funded

Job Code: \_\_\_\_\_ Position Type: \_\_\_\_\_ Position #: \_\_\_\_\_ Union Code: \_\_\_\_\_

**Commonwealth of Massachusetts**  
**Human Resources Division**



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Time of event: \_\_\_\_\_ am/pm      Date Reported: \_\_\_\_\_

Time work began on day of event: \_\_\_\_\_ am/pm

Event occurred: ☐ Before      ☐ During      ☐ After Work shift

What was employee doing just before the event occurred, *describe the activity as well as any tools, equipment or material the employee was using. Be specific. Examples:*

1. Walking down the hallway carrying supplies.
2. Restraining a patient.
3. Pouring cleaning solution into a bucket in order to wash the floor.

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Third Party Claim:      ☐ Yes      ☐ No

How did the injury or illness occur: *Example:*

1. Employee tripped over an electrical cord and fell to the floor
2. Patient was flailing and hit the employee
3. Cleaning solution splashed while being poured.

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What was the source of the injury or illness? *Source means the object or substance that directly harmed the employee. What object or substance directly harmed the employee?" Example:*

1. The floor
2. A patient
3. Cleaning solution

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Nature of Injury or illness: *Describe the Nature of the injury.* Example:

1. strained back
2. contusion
3. disorders of the eye

Body part(s) affected, a *narrative of body parts affected.* Example:

1. low back
2. face, arm
3. eyes

Injury/Illness detail (Choose Only from the Attached List):

Select Body Part: \_\_\_\_\_

Select Injury/illness: \_\_\_\_\_

Select One or More Event Categories:

- |                                      |   |   |
|--------------------------------------|---|---|
| <input type="checkbox"/> Fall        | <input type="checkbox"/> Lifting                                  | <input type="checkbox"/> MVA (Motor Vehicle Accident) |
| <input type="checkbox"/> Assault     | <input type="checkbox"/> Exposure to Harmful Substances           | <input type="checkbox"/> Repetitive Use               |
| <input type="checkbox"/> Equipment   | <input type="checkbox"/> Moving/Walking                           | <input type="checkbox"/> Stress/Heart Attack          |
| <input type="checkbox"/> Burn        | <input type="checkbox"/> Cut                                      | <input type="checkbox"/> Restraint                    |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Needlestick/Bloodborne Pathogen Exposure |   |

Severity of Injury or Illness:

- \_\_\_(1)Minor injury; no likely lost time; no likely medical bills  
\_\_\_(2)Small injury; no likely lost time; possible medical bills  
\_\_\_(3)Moderate injury; possible lost time; probable medical bills  
\_\_\_(4)Significant injury; probably 0 to 5 days of lost time and medical bills  
\_\_\_(5)Severe injury; probably 5 plus days lost time and medical bills

Where The Injury Occurred:

Building: \_\_\_\_\_

Injury/Illness Location: \_\_\_\_\_

Was the event the result of a violent act?

☐ Yes

☐ No

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Was the employee engaging in usual job activities: ☐ Yes ☐ No

If no, explain: \_\_\_\_\_

Injury reported to: \_\_\_\_\_

Did the injured/ill worker:

a. Lose consciousness? ☐ Yes ☐ No

b. Require medical treatment more than first aid? ☐ Yes ☐ No

c. Have an injury from a contaminated needlestick or other sharp device? ☐ Yes ☐ No

d. Have a significant work-related injury/illness diagnosed by a health care professional?  
☐ Yes ☐ No

e. Require transfer to another job or modified duty? ☐ Yes ☐ No

If employee died as a result of injury/illness, what was the date of death? \_\_\_\_/\_\_\_\_/\_\_\_\_

**Supervisor:** Are you satisfied that the injury occurred as stated? ☐ Yes ☐ No

If no, explain: \_\_\_\_\_

**Manager:** Are you satisfied that the injury occurred as stated? ☐ Yes ☐ No

If no, explain: \_\_\_\_\_

Was the event witnessed? ☐ Yes ☐ No

**If Yes, provide the names of witnesses and ask that each prepare a witness statement in their own handwriting and fax those statements to your claims adjuster.**

Witness: Name \_\_\_\_\_ Title \_\_\_\_\_ Tel \_\_\_\_\_

Name \_\_\_\_\_ Title \_\_\_\_\_ Tel \_\_\_\_\_

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Did the employee seek medical attention? ☐ Yes ☐ No

If so, where?

a. Facility: \_\_\_\_\_

b. Street: \_\_\_\_\_

c. Town: \_\_\_\_\_

d. Zip Code: \_\_\_\_\_

Did the employee seek medical attention away from the worksite? ☐ Yes ☐ No

Was employee treated in an emergency room? ☐ Yes ☐ No

Was employee hospitalized overnight as an in-patient? ☐ Yes ☐ No

Is employee a disabled veteran or has any other known disability? ☐ Yes ☐ No ☐ Unknown

Do you feel the employee would benefit from any referral to Rehabilitation? ☐ Yes ☐ No ☐ Unknown

Do you feel the claim warrants further investigation? ☐ Yes ☐ No

Please attach any information you feel would be useful to HRDWC Unit in managing this claim.

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**\*\* Please send the employees job description to your HRD Adjuster \*\***

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Position: \_\_\_\_\_

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Attachment for Body Parts and Injuries

Body Parts		
<b>Head</b>	Hip/Buttocks/Groin (Buttocks)	<b>Upper Extremities</b>
Brain	Hip/Buttocks/Groin (Groin)	Arm(s), unspecified (Left)
Ear(s), unspecified	Hip/Buttocks/Groin (Hips)	Arm(s), unspecified (Right)
Ear(s), external	Shoulder(s) (Left)	Arm(s), unspecified (Both)
Ear(s), internal	Shoulder(s) (Right)	Arm(s), unspecified (Armpit)
Eye(s) (Left)	Shoulder(s) (Both)	Arm(s), upper (Left)
Eye(s) (Right)	Trunk, Multiple	Arm(s), upper (Right)
Eye(s) (Both)	<b>Lower Extremities</b>	Arm(s), upper (Both)
Face, unspecified	Leg(s), unspecified (Left)	Elbow(s) (Left)
Jaw, Chin	Leg(s), unspecified (Right)	Elbow(s) (Right)
Mouth & Throat (Lips)	Leg(s), unspecified (Both)	Elbow(s) (Both)
Mouth & Throat (Multiple)	Knee(s) (Left)	Arm(s), lower (forearm) (Left)
Mouth & Throat (Tongue)	Knee(s) (Right)	Arm(s), lower (forearm) (Right)
Mouth & Throat (Tooth/teeth)	Knee(s) (Both)	Arm(s), lower (forearm) (Both)
Mouth & Throat (Unspecified)	Leg(s), lower (e.g. calf, shin) (Left)	Arm(s), multiple (Left)
Mouth & Throat (Internal (e.g. vocal cords, larynx))	Leg(s), lower (e.g. calf, shin) (Right)	Arm(s), multiple (Right)
Nose	Leg(s), lower (e.g. calf, shin) (Both)	Arm(s), multiple (Both)
Face, multiple	Leg(s), multiple (Left)	Wrist(s) (Left)
Face (Cheeks)	Leg(s), multiple (Right)	Wrist(s) (Right)
Face (Forehead)	Leg(s), multiple (Both)	Wrist(s) (Both)
Scalp	Leg(s), upper (e.g. thigh, hamstring) (Left)	Hand(s), not wrist/fingers (Left)
Skull	Leg(s), upper (e.g. thigh, hamstring) (Right)	Hand(s), not wrist/fingers (Right)
Head, Multiple	Leg(s), upper (e.g. thigh, hamstring) (Both)	Hand(s), not wrist/fingers (Both)
Head	Ankle (Left)	Finger(s)
<b>Neck</b>	Ankle (Right)	Upper Extremities, multiple (Left)
Neck & cervical vertebrae	Ankle (Both)	Upper Extremities, multiple (Right)
<b>Trunk</b>	Foot or Feet, except ankle/toe (Left)	Upper Extremities, multiple (Both)
Trunk, UNS	Foot or Feet, except ankle/toe (Right)	<b>Other</b>
Abdomen, internal organs/hernia	Foot or Feet, except ankle/toe (Both)	Other (Body system)
Back	Toe(s)	Other (Multiple body parts)
Chest/Breastbone (Internal organs)	Lower Extremities, multiple (Left)	Non-Classifiable
Chest/Breastbone (Ribs, breastbone)	Lower Extremities, multiple (Right)	
	Lower Extremities, multiple (Both)	

# Commonwealth of Massachusetts Human Resources Division



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Injuries	
<b>Acute Injuries</b>	<b>Mental disorders</b>
Amputation, enucleation	Mental disorders (Anxiety attacks)
Asphyxia, suffocation	Mental disorders (Other mental disorder or syndrome)
Burn, heat	Mental disorders (Stress)
Burn, chemical	<b>Other Work-related diseases/disorders</b>
Concussion	Other occupational disease
Contusion, crushing, bruise	Diseases of central nervous system
Cut, laceration, puncture (Except needlestick injury)	Diseases of peripheral nerves and ganglia
Cut, laceration, puncture (Needlestick/sharp injury )	Disease of the blood and blood forming organs
Cut, laceration, puncture (Splinter, chip (foreign body))	Disease of the gastro-intestinal tract
Dislocation	Carpal tunnel syndrome
Fracture	<b>Poisoning and toxic effects</b>
Effects of exposure to low temperature	Other poisoning due to toxic materials
Effects of environmental heat	Effects of lead
Hernia, rupture	<b>Respiratory conditions</b>
Effects of radiation	Other respiratory condition
Scratches, abrasion	Upper respiratory condition (e.g. allergic rhinitis)
Sprains, strains	Asthma
Multiple injuries	Asbestosis
Effects of atmospheric pressure	Silicosis
Bite/Burn/Other Injury (Bite, animal)	Influenza/Pneumonia (Influenza)
Bite/Burn/Other Injury (Bite, human)	Influenza/Pneumonia (Pneumonia)
Bite/Burn/Other Injury (Bite, insect)	<b>Skin conditions</b>
Bite/Burn/Other Injury (Burn, other)	Dermatitis
Bite/Burn/Other Injury (Other injury)	Infections of the skin
Electric shock/electrocution	Other skin conditions
<b>Heart/Circulatory System Conditions</b>	<b>Tumor, cancer</b>
Heart/Circulatory System (Heart condition/attack)	Tumor, unspecified
Heart/Circulatory System (High blood pressure)	Malignant Tumor
Heart/Circulatory System (Stroke or other circulatory condition)	Benign Tumor
<b>Hearing and eye disorders</b>	<b>Symptoms, ill defined conditions</b>
Hearing loss or impairment	Symptoms, ill defined conditions (Back pain, hurt back)
Conjunctivitis	Symptoms, ill defined conditions (Chest pains)
Other diseases of the eye	Symptoms, ill defined conditions (Dizziness)
<b>Infectious or parasitic diseases</b>	Symptoms, ill defined conditions (Headaches, migraine)
Tetanus	Symptoms, ill defined conditions (Nausea, vomiting)
Tuberculosis	Symptoms, ill defined conditions (Pain/Soreness, except back or chest)
Infectious/Parasitic Diseases (Lyme disease)	Symptoms, ill defined conditions (Sick building syndrome)
Infectious/Parasitic Diseases (Other infectious or parasitic diseases)	Symptoms, ill defined conditions (Other symptoms and ill defined conditions)
Hepatitis - viral	<b>Other</b>
<b>Inflammation of the joints or tendons</b>	No injury or illness
Joint Inflammation, etc. (Arthritis)	Damage to prosthetic devices
Joint Inflammation, etc. (Bursitis)	Non-classifiable (Exposure to saliva/body fluids)
Joint Inflammation, etc. (Other Inflammation of the joints)	Non-classifiable (Non-classifiable)
Joint Inflammation, etc. (Sciatica)	Complications peculiar to medical care
Joint Inflammation, etc. (Tendonitis)	

HRDWC 1/08

# Workers' Compensation Temporary Prescription ID Card

## »» To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved workers' compensation prescriptions (based on the guidelines established by your employer). Questions or need assistance locating a participating retail network pharmacy? Call the Express Scripts Patient Care Contact Center at **(800) 945-5951**.

## »» To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard claim limitation is \$150.00, or a day supply exceeding 14 days. This form is valid for up to 30 days from DOI. Limitations may vary. For assistance, call Express Scripts at **(888) 786-9640**.

### Pharmacy Processing Steps

- Step 1: Enter bin number 003858
- Step 2: Enter processor control A4
- Step 3: Enter the group number as it appears above
- Step 4: Enter the injured worker's nine-digit ID number
- Step 5: Enter the injured worker's first and last name
- Step 6: Enter the injured worker's date of injury  
(enter in DOI field in the format YYYYMMDD)

### Express Scripts

ID #: \_\_\_\_\_

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM/DD/YYYY

Group #: M5AA

Employee Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Thank you** for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare. *Please see other side for a list of participating retail network pharmacies.*

»» **To the Supervisor:** Please fill in the information requested for the injured worker.

### Employer Name

**Commonwealth of Massachusetts**

### Employee Information

\_\_\_\_\_  
First M Last

\_\_\_\_\_  
Street Address or PO Box

\_\_\_\_\_  
City State ZIP



EXPRESS SCRIPTS®



## Participating Retail Network Pharmacies

A & P	Drug Emporium	Major Value	Schnucks
Acme Pharmacy	Drug Fair	Marsh Drugs	Scolari's
Albertson's	Drug Town	Medic Discount	Sedano
Albertson's/Acme	Drug World	Medicap	<b>Shaw's</b>
Albertson's/Osco	Eckerd	Medistat	Shop 'N Save
Albertson's/Sav-On	Econofoods	Meijer	Shopko
Amerisource	EPIC Pharmacy	Minyard	ShopRite
Bergen	Network	NCS HealthCare	Snyder
Anchor Pharmacies	FamilyMeds	Neighborcare	<b>Stop &amp; Shop</b>
Arrow	Farm Fresh	Network	Sun Mart
Aurora	Farmer Jack	Pharmaceuticals	Super Fresh
Bartell Drugs	Food City	Northeast	Super Rx
Bigg's	Food Lion	Pharmacy Services	<b>Target</b>
Bi-Lo	Fred's	<b>Osco</b>	Texas Oncology
Bi-Mart	Gemmel	P & C Food	Srvs
<b>BJ's Wholesale</b>	Giant	Markets	The Pharm
<b>Club</b>	Giant Eagle	Pamida	Thrifty White
<b>Brooks</b>	Giant Foods	Park Nicollet	Times
Brookshire Brothers	<b>Hannaford</b>	Pathmark	Tom Thumb
Brookshire Grocery	Harris Teeter	Pavilions	Tops
Bruno	H-E-B	<b>Price Chopper</b>	Ukrop's
Carrs	Hi-School	Publix	United Drugs
Cash Wise	Pharmacy	Quality Markets	United
Coborn's	Hy-Vee	Raley's	Supermarkets
<b>Costco</b>	Jewel/Osco	Randalls	Vons
Cub	Kash n Karry	<b>Rite Aid</b>	Waldbaums
<b>CVS</b>	Keltsch	Rosauers	<b>Walgreens</b>
D&W	Kerr	Rx Express	<b>Wal-Mart</b>
Dahl's	<b>Kmart</b>	RXD	<b>Wegmans</b>
Dierbergs	Knight Drugs	Safeway	Weis
Discount Drugmart	Kroger	<b>Sam's Club</b>	Winn Dixie
Doc's Drugs	LeaderNet (PSAO)	Sav-On	
Dominicks	Longs Drug Store	Save Mart	

To search for participating pharmacies in your area, please use the "Find a Pharmacy" tool located at: <http://www.express-scripts.com/services/workerscompensation/>

**NOTE:** This form is not valid in the state of Ohio. For all other states, liability of a workers' compensation claim is not assumed based on the dispensing of medication(s) to a patient.