THE COMMONWEALTH OF MASSACHUSETTS

State Board of Retirement

ONE WINTER STREET, 8TH FLOOR, BOSTON, MA 02108

NOTICE OF INJURY

PLEASE COMPLETE AND RETURN FORM TO MAIN OFFICE (ADDRESS BELOW)

TO THE BOARD OF RETIREMENT:

This is to notify you that the following member received injuries incurred through accident in the line of duty or due to a hazard which occurred in the line of duty.

MEMBER INFORMATION (required)

Full Name:		Social Security#:	
Mailing Address:		City:	
State/Zip:		Telephone:	
Agency where employed :		Job or Position Title:	
Member Date of Birth:	/ /	Date of entry in service:	/ /
Marital Status:	☐ Married ☐ Single ☐ Divorced	Spouse Date of Birth:	/ /
If Married, Name of Spouse:		Spouse Maiden Name:	

INJURY INFORMATION

Note: These questions may NOT be left blank. Some statement must be made such as not taken to a hospital, no witnesses, etc.

Date and Time of Injury:		Nature of Injury:	
Cause of Injury: *If more space is needed, please use other side and check the box below.* ☐ Continued on other side			
Name of Doctor:		Hospital Name:	
Hospital Address:			
Witness #1 Name:		Telephone:	
Address:			
Witness #2 Name:		Telephone:	
Address:			

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MEMBER ACKNOWLEDGEMENT

The statements and facts contained in this document are correct, complete and accurately presented and are made under the pains and penalties of perjury.

I understand that **injuries incurred in the line of duty must be reported to the Retirement Board within 90 days** to give unlimited time coverage for Retirement based on accidental injuries or an accidental death benefit.

I also understand that if this Notice of Injury is not filed within ninety days an application for accidental disability retirement or for a death benefit based upon accidental injuries incurred more than two years prior to the date of application is void.

Member Signature _____ Date _____

Signature of Worker's Compensation Agent or Supervisor _____ Date _____

CAUSE OF INJURY(CONTINUED)

Member Signature _____ Date _____