The Commonwealth of Massachusetts
Division of Industrial Accidents
18 Tremont Street, Boston 8

WHEN REPLYING
PLEASE QUOTE I.A.B.
FILE NO.
ATTENTION OF:

November 23, 1954

CIRCULAR LETTER NO. 94

TO: ALL INSURERS

RE: STANDARD FORM FOR EMPLOYER'S FIRST REPORT OF INJURY

Gentlemen:

Enclosed herewith is copy of "standard Form for Employer's First Report of Injury" as presently approved by the Industrial Accident Board.

Objection has been raised to having questions on this form relating to nationality.

Many insurers are still using the form on which No. 14 reads as follows:

"14. (a) Nationality
(b) Citizen of
(c) Speak English."

Insurers are requested to kindly revise their forms so that these questions will no longer appear on them. Please advise employers to strike out these questions on any forms they may still have on hand.

Very truly yours,

EDWARD P. DOYLE
Secretary

EHG:CGP
ENC

SF1. 25m-8-54-912915

MASSACHUSETTS DIVISION OF INDUSTRIAL ACCIDENTS

STANDARD FORM FOR
Employer's First Report of Injury

Approved by I. A. I. A. B. C.

Within 48 hours after the occurrence of an accident, forward this report to the Industrial Accident Board, 18 Tremont Street, Boston 8, Massachusetts.

State's Number For:	File: ..... Carrier: ..... Employer: .....
Carrier's File No.	

(The spaces above not to be filled in by Employer)

Employer

1. Name of Employer .....
2. Office address: No. and St. ..... City or Town ..... State .....
3. (a) State name of insurance company with whom you are insured to provide payment to injured employees under the Workmen's Compensation Act .....
   (b) If not so insured, give number of employees on date of this report .....
4. Give nature of business (or article manufactured) .....

Time and Place

5. (a) Location of plant .....Department .....
   (b) Place where injury occurred .....(c) State if injury occurred on or off employer's premises.....
6. Date of Injury .....19.....Day of week .....Hour of day.....A.M. .....P.M.
7. Date disability began .....19.....A.M. .....P.M. 8. Was injured paid in full for this day.....
9. When did you or foreman first know of injury .....
10. Name of foreman .....

Injured Person

11. Name of injured ..... (First Name) (Middle Initial) (Last Name)
12. Address: No. and St. .....City or Town ..... State .....
13. Check (√) Married....., Single....., Widowed....., Widower....., Divorced.....; Male....., Female.....
14. Age.....Did you have on file employment certificate or permit .....
15. (a) Occupation when injured .....(b) Was this his or her regular occupation.....
    (If not, state in what department or branch of work regularly employed) .....
16. (a) How long employed by you .....(b) Piece or time worker.....(c) Wages per hour $.....
17. (a) No. hours worked per day .....(b) Wages per day $.....
    (c) No. days worked per week .....(d) Average weekly earnings $.....
    (e) Where applicable give number of meals furnished employee each week, and estimated value per day, week, or month of any lodging, fuel or other advantages furnished employee .....

Cause of Injury

18. Machine, tool or thing causing injury .....19. Kind of power (hand, foot, electrical, steam, etc.) .....20. Part of machine on which accident occurred .....
21. (a) Was safety appliance or regulation provided.....(b) Was it in use at time.....
22. Was accident caused by injured's failure to use or observe safety appliance or regulation .....
23. Describe fully how accident occurred, and state what employee was doing when injured.....
    .....
    .....
    .....
24. Names and addresses of witnesses .....
    .....

Nature of Injury

25. Nature and location of injury (describe fully exact location of amputations or fractures, right or left).....
    .....
26. Probable length of disability .....27. Has injured returned to work .....
    If so, date and hour .....At what wage $.....
28. At what occupation .....
29. Name and address of physician .....
    (b) Name and address of hospital .....

Fatal Cases

30. Has injured died ..... If so, give date of death.....

Firm name ..... Signed by ..... Official Title .....

Date of this report.....