FORM 170



The Commonwealth of Massachusetts Department of Industrial Accidents – Department 170 Workers' Compensation Trust Fund

DIA USE ONLY

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

AFFIDAVIT OF EMPLOYEE IN APPLICATION FOR TRUST FUND BENEFITS

		, do swear and depose as follows	;:
(Name of employee	,		
		·	ı
Home telephone	#	·	
On the date of my	y injury my employer was _		_•
The address of m	y employer is		_•
My supervisor's r	name is		_•
While working for	or my employer, I was injure	ed on	_•
TD1	1 .	(Date of Injury)	
The injury occurr	ed at(Address, city	r and town)	- •
	•	,	
Witnesses to my		dress of witness)	-
	(Traine and add	dress of witnessy	
	(Name and add	dress of witness)	-
I have been inform		ne time of my injury, did not carry wachusetts law (M.G.L. c. 152, §25A	
compensation ins).
•	g to the Workers' Compensa	ation Trust Fund (WCTF) for approp	,
I am now applyin benefits.	injury, I was earning wages	ation Trust Fund (WCTF) for appropriation of \$ per week from my	priate
I am now applying benefits. At the time of my by CASH - CHEO (Circle one)	injury, I was earning wages	s of \$ per week from my	priate
I am now applying benefits. At the time of my by CASH - CHEC (Circle one)	y injury, I was earning wages CK. THE PAINS AND PENAL DAY OF	s of \$ per week from my LTIES OF PERJURY 20	priate