Insurance Company: **MBSIG Safety Group**
Cabot Risk Strategies, LLC
15 Cabot Road,
Woburn, MA 01801
Fax: 781-376-9907
Tel: 800-222-5963

Employer: **Growthways, Inc.**
41 North Pearl Street Brockton, MA 02301
(508) 941-6505 HR Office: ext 19 or 26

First Report of Injury - **Notify AOC immediately, file form with HR office by next day.**

HR use only: Recvd by HR on : _____ Who Sent to WC : _____ on: _____ Fax __ Eml__
If will be missing work: HR will notify AOC, Coors, Mgr regarding being out due to injury, check other schedules.
Likely to be out 5 or more days? _____ (~~if yes, will need form 101 and prepare wage report~~).

HR verified report with employee on: _____ with supervisor on: _____ Claim#: _____
Returned to work on: _____ Any restrictions: _____ Modified Duty?_____ Claim closed on: _____

Employee Information:

Name: _____ Position: _____ Date of Birth:_____
Street: _____ City: _____ ST:____ Zip: _____
Phone: (_____) _____ Date of Hire: _____ (HR will fill this in)

Incident Information:

Date: _____ Time: _____ Location: _____ Room in building: _____
First person notified: _____ Date: _____ Time:_____
Name(s) of other people present: _____
Medical treatment beyond first aid?: _____ Facility: _____ Dr. Name: _____
Left during shift? Y__ N__ If yes, returned to finish shift? Y__ N__ #Hours lost: _____

If employee is not immediately available, HR or Supervisor should describe incident & injury:

_____

_____

Name of person writing above statement: Date:

II. EMPLOYEE'S STATEMENT

Describe the Incident in Detail:

Part of Body Injured (Be Specific: Right or Left, etc.):

Employee Signature:	**Date:**

MEDICAL RELEASE AUTHORIZATION

I hereby authorize any hospital / clinic, physician, Nurse Practitioner, Physician Assistant, chiropractor, or any other person / provider who has attended to / treated me to furnished / release any and all information and facts regarding my injury / illness due to the above workers' compensation claim, including reports and records, results of diagnostic tests, diagnosis, treatment and prognosis, estimates of disability, and recommendations for further treatment, to representatives of the Massachusetts Bay Self-Insurance Group. I also authorize the release of Utilization Review information / determinations regarding my injury / illness due to the above workers' compensation claim, to the Massachusetts Bay Self-Insurance Group Medical Case Consultant / Nurse Case Manager.

This information is to be used for the purpose of evaluating and handling my claim for injury as a result of an incident occurring on the above noted date of injury and for no other purpose, now or in the future. I agree that a photocopy of this authorization shall be as valid as the original.

Date: _____

Employee signature: _____

Please Print Employee Name: _____