

**Town of Canton - Employee Accident / Incident Report**  
**Massamont, 280 Summer Street, 4<sup>th</sup> floor, Boston, MA 02210**  
**FIRST REPORT OF INJURY – MEDICAL ONLY**  
**If employee is disabled for 5 or more days from work,**  
**NOTIFY Jody Middleton, Human Resource Administrator IMMEDIATELY**  
**@ 781-821-2936 or [jmiddleton@town.canton.ma.us](mailto:jmiddleton@town.canton.ma.us)**

**EMPLOYER**

**EMPLOYER:** Town of Canton      **Telephone #:** 781-821-2936      **Fax:** 781-575-6602  
**Contact Name:** Jody Middleton, Human Resource Administrator      **Address:** 801 Washington Street, Canton, MA 02021

**EMPLOYEE**

Name: \_\_\_\_\_ Home&Cell Telephone #: \_\_\_\_\_  
Address: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Date of hire: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Job Title: \_\_\_\_\_ Department& School: \_\_\_\_\_  
Supervisor \_\_\_\_\_ Supervisor Phone Number: \_\_\_\_\_  
Hours and Days worked each week \_\_\_\_\_

**ACCIDENT / INJURY**

Date of Injury: \_\_\_\_\_ Time: \_\_\_\_\_ Location (incl. room & building) \_\_\_\_\_  
Body part (if applicable include whether Left or Right side) \_\_\_\_\_  
Type of injury (strain, laceration, etc): \_\_\_\_\_  
Dates & Days out of work: \_\_\_\_\_ Estimated Length of Disability: \_\_\_\_\_  
Describe how accident occurred: \_\_\_\_\_  
\_\_\_\_\_  
Name of witness(es): \_\_\_\_\_  
Person to whom accident was reported: \_\_\_\_\_ Date reported: \_\_\_\_\_  
 Have you injured this body part in the past?     Yes     No    \_\_\_\_\_ When  
Was medical attention sought?     Yes     No    If yes, where?: \_\_\_\_\_

**Information Release:** I hereby authorize the Town of Canton and Massamont Insurance Agency, or any of its representatives to be furnished only information and facts regarding medical services rendered to me by any medical provider, including reports/records, results of diagnosis, treatment and prognosis, estimates of disability and recommendations for further treatment. 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 or about the above indicated date of injury for no other purpose, now or in the future.

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Supervisor comments:** \_\_\_\_\_  
\_\_\_\_\_  
**Supervisor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please fax or email completed form to:**  
Jody Middleton  
Human Resource Administrator  
Fax: 781-575-6602  
e-mail: [jmiddleton@town.canton.ma.us](mailto:jmiddleton@town.canton.ma.us)

# Town of Canton

## SUPPLEMENTAL SUPERVISOR'S REPORT

Name of Employee Injured: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

1. Were there any witnesses to the incident? \_\_\_\_\_

Who? \_\_\_\_\_

\_\_\_\_\_ School Nurse Initials

2. Is the witness' description of the accident compatible with the employee's description?

\_\_\_\_\_

If not, list differences: \_\_\_\_\_

\_\_\_\_\_

3. Has the employee been disciplined recently? \_\_\_\_\_

Please Describe \_\_\_\_\_

\_\_\_\_\_

4. Is the employee recently off his/her probationary period? \_\_\_\_\_

5. To your knowledge, had the employee ever complained about his/her back (or whatever body part) before? \_\_\_\_\_ Please describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

6. Are there any other facts that should be considered in evaluating this claim?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Supervisor Signature \_\_\_\_\_

\_\_\_\_\_ Date

Recommendation(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

School Nurse Signature \_\_\_\_\_

\_\_\_\_\_ Date