Please send completed form to:
Gayle McCracken
Dedham Town Hall, Human Resources Department
Tel# 781-751-9142
Fax#781-751-9138
Gmccracken@dedham-ma.gov

Town of Dedham
First Report of Injury
Employee Accident/Incident Report

EMPLOYER

Employer: Town of Dedham ______ Telephone #: 781-751-9142 ______
Address: 450 Washington Street, Dedham, MA. 02026 ______

EMPLOYEE

Name:		Telephone #:
Address:		
Social Security #:	Date of hire:	Date of birth:
Job Title:		Department:

ACCIDENT/INJURY

Date of accident:	Time:	Location:
Body part:	Type of injury (strain, laceration, etc.)	
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?:______ (If this changes, please notify Gayle McCracken)		
Did employee return to work: Yes______No______If yes, date and time:___/___/___ ______AM PM		

Information Release: I hereby authorize the Town of Dedham and Massachusetts Education & Government Association 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 the 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:______________________________________

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Supervisor Signature:______________________ Date:______________

Supervisor's Incident Investigation Report

To be filled out and signed by supervisor and submitted within 24 hours after incident. Use this form to gather facts and contributing factors to a workplace injury as part of your incident investigation and to develop injury prevention strategies.

PART I.

Name of Injured Employee:		Date of Investigation:
Job Title:		Department Location:
Date of Accident:	Time of Accident: AM PM	Did they go to the doctors? Yes No
Exact location of Accident:		List any days missed from work:

PART II. DESCRIBE INCIDENT

Describe what activity the injured person was doing at time of accident:		
Describe any visible signs of injury (examples: walking with a limp, swelling etc.)		
Describe any symptoms reported by the injured person (examples: pain, numbness, trouble lifting arm, etc.)		
What were the atmospheric and surface conditions at the place of incident? (rainy, icy, dry, sunny, cloudy, hot, cold)		
What tool or equipment was involved?		Is the tool or equipment appropriate for the task involved? Yes No
Describe any tool or equipment failure related to the incident:		
Describe any materials related to the incident:		
Is there a written procedure for this task? Yes No	If so, was the procedure followed? Yes No	Was the employee working under supervisor at the time of incident? Yes No
Did this injury occur while the employee was working overtime? Yes No		If so, how many consecutive hours were worked prior to injury?
Was all required PPE worn at the time of the incident? Yes No		

PART III: CORRECTIVE ACTION PLAN

What corrective actions need to be taken to prevent a recurrence?

Investigated by:____ Date:________________________________

Reviewed & approved by:______________________________ Date:______________________________________

Submit to: Gayle McCracken, Human Resources Director, gmccracken@dedham-ma.gov (Fax 781-751-9138)