

FORM IOD-1
Town of Needham
NOTICE OF PUBLIC SAFETY EMPLOYEE ACCIDENT

This form is to be submitted within 24 hours after an accident which results in an injury or illness, but may be filed later if the illness or injury develops or becomes more severe at a later date.

Date of this Report: _____

Department: _____

Name of Injured: _____
First Middle Last

Social Security Number: _____

Address: _____

Job Title: _____

Date of Birth: _____

Marital Status: _____ Married _____ Single

Gender: _____ Male _____ Female

Nature of injury/illness: _____

Place where injury
or illness occurred: _____

Date of injury: _____

Time of injury: _____

Name of witness(es): _____

Describe fully how accident occurred and state what employee was doing when injured:

Did employee seek immediate medical treatment? _____

Name and location of medical provider: _____

Has employee returned to work? _____ Yes _____ No

Signature of employee or person completing form

This form should be completed by the employee. If the employee is unable to complete the report due to illness or injury, it should be completed by the supervisor.



TOWN OF NEEDHAM

TOWN HALL
1471 Highland Avenue
Needham, MA 02192

TEL: (617) 455-7530
FAX: (617) 449-4569

PERSONNEL DEPARTMENT

FORM IOD-2F
Town of Needham
Authorization for Release of Information
Alleged or Approved Work-related Injury

I understand that the Town of Needham, through its occupational health consultant Buckler, Irvin and Graf (BIG) requires certain medical information and other records which are directly related to my work-related injury. I further understand that all information that I provide to the Town of Needham/BIG will be used only for claims directly relating to my work-related injury and that the Town of Needham/BIG will safeguard the confidentiality of this information.

I hereby authorize the individuals, agencies, institutions and facilities in the possession of such information to release complete records of the diagnosis, any treatment or examinations provided, and any other information pertaining to my work-related injury to the Town of Needham/BIG.

Employee Name: _____

Date of Injury: _____

Nature of Injury: _____

Date(s) of Treatment: _____

This authorization or a photocopy will be equally acceptable as the original document and will authorize the individuals, agencies, institutions and/or facilities to furnish all information regarding my condition for the purposes stated above.

Employee Signature

Date



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PERSONNEL DEPARTMENT

FORM IOD-3F Town of Needham Work-Related Injury Medical Certification Form

In accordance with M.G.L. Chapter 41 Sections 100 and 111F and the collective bargaining agreement between the Town and the Union, the employee named below has requested benefits relating to an alleged work-related injury. In order for the Town to determine whether such benefits are warranted, the following information must be provided.

Employee's Name: _____
Date of Injury: _____
Nature of Injury: _____

Treating Provider: _____
Address: _____

Federal ID: _____

Diagnosis: _____
ICD-9 Code: _____

Procedure Requested for
Pre-certification: _____
CPT Code: _____
Date of Procedure: _____

Prognosis for Further Treatment:

Expected Return to Work Date:

Physician's Opinion as to Causality:

Signature of Treating Physician

Date

I understand that if my request for IOD status is approved, I must report for physical/psychological examinations at reasonable intervals when so requested.

I understand that if my request for IOD status is approved, I must comply with all requests for information relating to my approved, work-related injury.

Signature of Employee

Date: _____

Chief Comments:

Signature, Chief

Date: _____

For Personnel Department Use Only

APPROVED

Date: _____

PHYSICAL/PSYCHOLOGICAL EXAM REQUIRED

Date: _____

DENIED

Date: _____

Chairman, Board of Selectmen or Designee