

ACCIDENT REPORTING FORM

123 Interstate Drive • P.O. Box 3600
 West Springfield, Massachusetts 01090-3600
 (413) 781-5940 • fax (413) 739-9330

PLEASE PRINT OR TYPE:

E M P L O Y E E	1. Employee Name (Last, First, MI)		2. Home Telephone	3. Social Security Number*
	4. Home Address (No. & Street, City, State, Zip Code)		5. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	6. No. of Dependents
	7. Date of Hire (MM/DD/YY):	8. Date of Birth (MM/DD/YY):	9. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	10. Hourly Wage
	11. Piece or Hourly Worker? <input type="checkbox"/> Piece <input type="checkbox"/> Hourly	12. Hours Worked Per Day	13. Days Worked Per Week	14. Avg. 52-Week Wage: \$ <input type="checkbox"/> Estimated or <input type="checkbox"/> Actual

E M P L O Y E R	15. Employer Name Anna Maria College		16. Employer Self-Insured? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	17. Federal Tax ID 04-2002060
	18. Employer Address (No. & Street, City, State, Zip Code) 50 Sunset Lane, Paxton, MA 01612		19. Employer Telephone 508-849-3300	20. Industry Code 82
	21. Insurance Carrier: Name and Address of Branch Responsible for This Case (Not Local Agent or Adjuster) NEEIA Compensation Inc., PO Box 3600, West Springfield, MA 01090			
	22. Worker's Compensation Policy Number		23. OSHA Case File Number (if applicable)	

I N J U R Y I N F O R M A T I O N	24. Date of Injury (MM/DD/YY):	25. Time of Injury <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	26. Source of Injury (e.g., Machine, Tool, Substance, etc.)	
	27. Address Where Injury Occurred (if different from #18 above)		28. On Employer's Premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	29. Employer Location Code
	30. Regular Occupation		31. Regular Occupation When Injured? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	32. To Whom Was Injury Reported?			33. Date Reported (MM/DD/YY):
	34. Nature of Injury(ies) (Burn, Fracture, Cut, etc.)			
	35. Injured Body Part(s) Description (Arm, Leg, Back, etc.)			
	36. Physician Name and Address			
	37. Hospital Name and Address			
	38. Describe How Injury Occurred (e.g., Struck by....., Fell from....., Exposed to...)			
	39. If Employee Has Returned to Work, Date of Return (MM/DD/YY):		40. Returned to Regular Occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No	

41. Preparer's Name (Please Print or Type)		42. Preparer's Title	
43. Preparer's Signature		44. Date Prepared (MM/DD/YY):	