HUMAN RESOURCES
94 North Elm Street, Suite 201
Westfield, MA 01085
Tel: (413) 572-6550
Fax: (413) 572-6518

Katherine Bourque, *Director of Human Resources*

MEMO

To: All Employees
From: Katherine Bourque, Director of Human Resources
Date: March 2, 2023
RE: Work-Related Injury Procedures

All work related injuries regardless of whether or not medical attention is needed, should be reported to the Office of Human Resources.

Attached is the most current packet of injury forms and instructions. The packet includes the following required forms: Employee's Report of Injury/Incident; Medical Authorization & Release of Information; and Eyewitness Accident/Incident Report. All forms are to be completed with signatures and returned to School HR on or before the next business day after the incident.

Please discard all previous workers compensation packets that you have in your buildings.

The City's primary source for medical attention for work-related injuries is:

Work Connection
Holyoke Medical Center
575 Beech Street
Holyoke, MA 01040

Please note that payroll clerks should be designating time out for work related injuries appropriately, with the reason code 60 - Worker's Compensation.

If you have any questions or concerns, please reach out to School HR.

Workers Compensation Procedures – Schools

What to do when an injury occurs:

1. Employee should immediately report the injury to the supervisor
2. Employee must complete the following forms at the time of reporting, if possible. Forms should be completed in their entirety, including a signature
    a. Employee's Report of Injury Accident
    b. Medical Authorization & Release of Information
3. Any eyewitnesses must complete Eyewitness Accident/Incident Report, if applicable
4. Call School Human Resources on the day of the injury to advise of the incident
5. All accident reporting forms should be completed and received by the Human Resource Department no later than the next business day

If/When seeking medical attention:

1. Primary source for medical attention:

    Work Connection

    575 Beech St

    Holyoke, MA, 01040

2. After each and every medical/follow-up visit, the employee should be returning a form indicating their current status and treatment to School Human Resources. It is the employee's responsibility to make sure all medical forms are turned into School Human Resources after each visit.

EMPLOYEE'S REPORT OF INJURY/INCIDENT

INJURED EMPLOYEE INFORMATION

Name			Social Security Number
Address	City	Zip Code	Home Phone Number

Date of Birth (MM/DD/YY)	Gender	Marital Status	Date of Hire (MM/DD/YY)

Social Security #	Department
Supervisor Name	Supervisor Phone #

INJURY INFORMATION

Date of Injury (MM/DD/YY)	Time of Injury (AM/PM)	Date Reported (MM/DD/YY)	On Employer's Premises (Y/N)?

Address Where Injury Occurred
Describe How Injury Occurred (e.g., struck by ..., exposed to...)
Nature of Injury (e.g., burn, fracture, cut, etc.)
Source of Injury (e.g., machine, tool, substance, etc.)
Injured Body Part(s) Description (e.g., arm, leg, back, etc.)
Name of Witnesses to the Injury
Additional Notes/Information

Employee Name (Print)	Supervisor Name (Print)
Signature	Signature
Date Signed (MM/DD/YY)	Date Signed (MM/DD/YY)

MEDICAL AUTHORIZATION AND RELEASE OF INFORMATION

EMPLOYEE: _____

TO: CMS Associates, Inc. **DATE:** _____

City of Westfield Personnel Department

City of Westfield

I, _____, hereby authorize and request any and all persons, businesses, government departments and agencies to release to my employer, the City of Westfield, and its authorized representatives, CMS Associates, Inc. any and all requested medical information concerning or related to my injury or illness designated below. This release includes but is not limited to all medial records, charts, files, diagnoses, prognoses, medications or therapies prescribed, test results, x-rays, laboratory reports and such other similar information concerning or related to my illness or injury designated below. A photocopy of this document shall serve and be as valid as the original. This release shall be good and valid until or unless withdrawn by me in writing.

I am willing that a photo static copy of this authorization be accepted with the same authority as the original.

This information is to be used for purposes of evaluating and handling my line of duty/ worker's compensation injury, and for no other purpose, now or in the future.

THIS AUTHORIZATION EXPIRES ON CONCLUSION OF CLAIM.

Injury or illness involved: _____

Date of injury or illness: _____

SIGNATURE/DATE: _____

WC/IOD

EYEWITNESS ACCIDENT/INCIDENT REPORT

NAME OF EYEWITNESS: _____

ADDRESS OF EYEWITNESS: _____

_____

DEPARTMENT: _____ **POSITION:** _____

VICTIM'S NAME: _____

DATE OF ACCIDENT: _____ **DATE OF REPORT:** _____

I, the undersigned, do hereby state the following with regard to an accident/incident involving the above named victim, and do so with the full knowledge of penalties under the law with respect to perjury:

_____

_____

_____

_____

_____

_____

_____

_____

Subscribed and sworn to under the pains and penalties of perjury:

EYEWITNESS SIGNATURE / DATE:

_____