

CITY OF HAVERHILL

FORM 118 - EMPLOYER'S NOTIFICATION TO INSURER OF MEDICAL ONLY INJURIES

(If an injury has resulted in 5 or more lost work days, File "Employer's First Report of Injury" – Form 101)

PLEASE PRINT OR TYPE:

| | | | | | |
|---|---|--|--|--|--|
| 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 <input type="checkbox"/> Non-Binary | | 10. Hourly Wage | |
| 11. Worker <input type="checkbox"/> Salary <input type="checkbox"/> Hourly | 12. Hours Worked Per day | 13. Days Worked Per Week | 14. Avg. 52-Week Wage \$ <input type="checkbox"/> Estimated <input type="checkbox"/> Actual | | |
| 15. Employer Name CITY OF HAVERHILL DEPARTMENT: | | 16. Employer Self-Insured? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 17. Federal Tax ID 04-6001392 | |
| 18. Employer Address (No. & Street, City, State, Zip Code) 4 Summer Street Room 306 Haverhill, MA 01830 | | 19. Employer Telephone (978) 374-2357 | | 20. Industry Code N/A | |
| 21. Insurance Carrier: Name and address of Branch responsible for this case (Not Local Agent or Adjuster) CITY OF HAVERHILL 4 Summer Street Room #306 Haverhill, MA 01830 ATTN: Human Resources | | | | | |
| 22. Worker's Compensation Policy Number N/A | | | 23. OSHA Case File Number (if applicable) N/A | | |
| 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 N/A | |
| 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: (Burn, Fracture, Cut, Bruise, etc.) | | 35. Injured Body part(s) Description (Arm, Leg, Back, Right/Left Etc.) | | | |
| 36. Describe How Injury Occurred in DETAIL (e.g., Struck by ____, Fell from ____, Exposed to ____...) | | | | | |
| 37. Please select applicable visit type <input type="checkbox"/> Walk-In <input type="checkbox"/> Emergency Room visit <input type="checkbox"/> Primary Care Doctor visit <input type="checkbox"/> Did not seek medical attention <div style="display: flex; justify-content: space-between; font-size: small;"> <div style="width: 20%;">Hospital Name:</div> <div style="width: 20%;">Doctors Name</div> <div style="width: 20%;">Address</div> <div style="width: 20%;">City, State ZIP</div> </div> | | | | | |
| 38. If Employee Has Returned to Work, Date of return: | | 39. Returned to Regular Duties? <input type="checkbox"/> YES Date: <input type="checkbox"/> NO | | 40. Returned to Modified Duties? <input type="checkbox"/> YES Date: <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): | | | |

THIS FORM WHEN COMPLETED SHOULD BE SENT TO CITY HALL, ROOM 306, 4 SUMMER STREET, HAVERHILL, MA OR EMAILED TO HRD@HAVERHILLMA.GOV.

HR OFFICE USE ONLY
 WC Claim #: _____
 Entered by: _____



Haverhill

Human Resources Department, Room 306
Phone: (978) 374-2357 Fax: (978) 374-2343

Denice McClanahan HR Director – dmcclanahan@haverhillma.gov

Christine Caminero, HR Technician – ccaminero@haverhillma.gov

Christina Carrie, HR Technician – ccarrie@haverhillma.gov

Parisa Daneshmand, Head Clerk/Floater – ccarrie@haverhillma.gov

MEDICAL AUTHORIZATION FORM

Employee: _____

Claim #: _____

DATE: _____

TO: _____

and any other physicians, hospitals, clinic or medical care provider, presently unknown to me, who may have or subsequently acquire information concerning my physical condition.

You are hereby authorized to give to _____ or any of its representatives, all information, facts and particulars, including reports, results from diagnostic tests, x-rays and statements of charges which may be requested regarding my medical condition, diagnosis, treatment rendered, prognosis, estimates of disability or recommendations for further treatments and to furnish them copies of such reports. You are further authorized to allow any physician appointed by them to review all such reports, records and x-rays in your possession.

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

"This information is to be used for the purposes of evaluating and handling my injury, and for no other purpose, now or in the future."

THIS AUTHORIZATION EXPIRES ON CONCLUSION OF THE CLAIM

EMPLOYEE SIGNATURE: _____