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	6. No. of Dependents
(, , , ,	□Single	
		☐Married	
7. Date of Hire (MM/DD/YY):	8. Date of Birth (MM/DD/YY):	9. Sex	10. Hourly Wage
7. Date of Hire (MIM/DD/111).	8. Date of Birth (MM/DD/111):	9. Sex	10. Hourly wage
11. Worker	12. Hours Worked Per day	13. Days Worked Per Week	14. Avg. 52-Week Wage \$
☐ Salary ☐ Hourly	,		☐Estimated ☐Actual
_ ,_ ,			
15. Employer Name		16. Employer Self-Insured?	17. Federal Tax ID
CITY OF HAVERHILL		⊠YES □NO	04-6001392
DEPARTMENT:			010001002
18. Employer Address (No. & Street, City,		19. Employer Telephone	20. Industry Code
4 Summer Street Rooi	m 306	(978) 374-2357	N/A
Haverhill, MA 01830		(976) 374-2337	IN/A
21. Insurance Carrier: Name and address	of Branch responsible for this case (Not Lo	ocal Agent or Adjuster)	1
CITY OF HAVERHILL			
4 Summer Street Room a	# 306		
Haverhill, MA 01830			
ATTN: Human Resource	_	T	
22. Worker's Compensation Policy Number		23. OSHA Case File Number (if app	•
N/			N/A
24. Date of Injury (MM/DD/YY)	25. Time of Injury A.M. P.M.	26. Source of Injury (e.g., Machine,	
27. Address Where Injury Occurred (if diffe	rent from #18 above)	28. On Employer's Premises?	29. Employer Location Code
		☐ YES ☐ NO	N/A
20 Pogular Occupation			
30. Regular Occupation		31. Regular Occupation When Injure	
30. Regular Occupation 32. To Whom Was Injury Reported?			
,		31. Regular Occupation When Injure YES NO 33. Date Reported (MM/DD/YY):	od?
,	Bruise, etc.)	31. Regular Occupation When Injure YES NO	od?
32. To Whom Was Injury Reported?	Bruise, etc.)	31. Regular Occupation When Injure YES NO 33. Date Reported (MM/DD/YY):	od?
32. To Whom Was Injury Reported?	Bruise, etc.)	31. Regular Occupation When Injure YES NO 33. Date Reported (MM/DD/YY):	od?
32. To Whom Was Injury Reported? 34. Nature of Injury: (Burn, Fracture, Cut, E		31. Regular Occupation When Injure YES NO 33. Date Reported (MM/DD/YY): 35. Injured Body part(s) Description	od?
32. To Whom Was Injury Reported?		31. Regular Occupation When Injure YES NO 33. Date Reported (MM/DD/YY): 35. Injured Body part(s) Description	od?
32. To Whom Was Injury Reported? 34. Nature of Injury: (Burn, Fracture, Cut, E		31. Regular Occupation When Injure YES NO 33. Date Reported (MM/DD/YY): 35. Injured Body part(s) Description	od?
32. To Whom Was Injury Reported? 34. Nature of Injury: (Burn, Fracture, Cut, E		31. Regular Occupation When Injure YES NO 33. Date Reported (MM/DD/YY): 35. Injured Body part(s) Description	od?
32. To Whom Was Injury Reported? 34. Nature of Injury: (Burn, Fracture, Cut, E		31. Regular Occupation When Injure YES NO 33. Date Reported (MM/DD/YY): 35. Injured Body part(s) Description	od?
32. To Whom Was Injury Reported? 34. Nature of Injury: (Burn, Fracture, Cut, E		31. Regular Occupation When Injure YES NO 33. Date Reported (MM/DD/YY): 35. Injured Body part(s) Description	od?
32. To Whom Was Injury Reported? 34. Nature of Injury: (Burn, Fracture, Cut, E		31. Regular Occupation When Injure YES NO 33. Date Reported (MM/DD/YY): 35. Injured Body part(s) Description	od?
32. To Whom Was Injury Reported? 34. Nature of Injury: (Burn, Fracture, Cut, E 36. Describe How Injury Occurred in DETA		31. Regular Occupation When Injure YES NO 33. Date Reported (MM/DD/YY): 35. Injured Body part(s) Description	od?
32. To Whom Was Injury Reported? 34. Nature of Injury: (Burn, Fracture, Cut, E 36. Describe How Injury Occurred in DETA 37. Please select applicable visit type	NIL (e.g., Struck by, Fell from, Exposite the structure of the stru	31. Regular Occupation When Injure YES NO 33. Date Reported (MM/DD/YY): 35. Injured Body part(s) Description Description Primary Care Doctor visit Doctors Name	d? (Arm, Leg, Back, Right/Left Etc.)
32. To Whom Was Injury Reported? 34. Nature of Injury: (Burn, Fracture, Cut, E 36. Describe How Injury Occurred in DETA 37. Please select applicable visit type	ML (e.g., Struck by, Fell from, Exposite the structure of the struc	31. Regular Occupation When Injure YES NO 33. Date Reported (MM/DD/YY): 35. Injured Body part(s) Description Description Primary Care Doctor visit Doctors Name Address	(Arm, Leg, Back, Right/Left Etc.)
32. To Whom Was Injury Reported? 34. Nature of Injury: (Burn, Fracture, Cut, E 36. Describe How Injury Occurred in DETA 37.Please select applicable visit type Walk-In	NIL (e.g., Struck by, Fell from, Exposite the structure of the stru	31. Regular Occupation When Injure YES NO 33. Date Reported (MM/DD/YY): 35. Injured Body part(s) Description Description Primary Care Doctor visit Doctors Name Address City, State ZIP	d? (Arm, Leg, Back, Right/Left Etc.) Did not seek medical attention
32. To Whom Was Injury Reported? 34. Nature of Injury: (Burn, Fracture, Cut, E 36. Describe How Injury Occurred in DETA 37.Please select applicable visit type Walk-In 38. If Employee Has Returned to Work,	ML (e.g., Struck by, Fell from, Exposite the structure of the struc	31. Regular Occupation When Injure YES NO 33. Date Reported (MM/DD/YY): 35. Injured Body part(s) Description Description Primary Care Doctor visit Doctors Name Address City, State ZIP 39. Returned to Regular Duties?	Did not seek medical attention
32. To Whom Was Injury Reported? 34. Nature of Injury: (Burn, Fracture, Cut, E 36. Describe How Injury Occurred in DETA 37.Please select applicable visit type Walk-In	ML (e.g., Struck by, Fell from, Exposite the structure of the struc	31. Regular Occupation When Injure YES NO 33. Date Reported (MM/DD/YY): 35. Injured Body part(s) Description Description Primary Care Doctor visit Doctors Name Address City, State ZIP 39. Returned to Regular Duties? YES Date:	Did not seek medical attention Did Nodified Duties? YES Date:
32. To Whom Was Injury Reported? 34. Nature of Injury: (Burn, Fracture, Cut, E 36. Describe How Injury Occurred in DETA 37.Please select applicable visit type Walk-In 38. If Employee Has Returned to Work, Date of return:	ML (e.g., Struck by, Fell from, Exposite the structure of the struc	31. Regular Occupation When Injure YES NO 33. Date Reported (MM/DD/YY): 35. Injured Body part(s) Description Description Primary Care Doctor visit Doctors Name Address City, State ZIP 39. Returned to Regular Duties? YES Date: NO	Did not seek medical attention
32. To Whom Was Injury Reported? 34. Nature of Injury: (Burn, Fracture, Cut, E 36. Describe How Injury Occurred in DETA 37.Please select applicable visit type Walk-In 38. If Employee Has Returned to Work,	ML (e.g., Struck by, Fell from, Exposite the structure of the struc	31. Regular Occupation When Injure YES NO 33. Date Reported (MM/DD/YY): 35. Injured Body part(s) Description Description Primary Care Doctor visit Doctors Name Address City, State ZIP 39. Returned to Regular Duties? YES Date:	Did not seek medical attention Did Nodified Duties? YES Date:
32. To Whom Was Injury Reported? 34. Nature of Injury: (Burn, Fracture, Cut, E 36. Describe How Injury Occurred in DETA 37.Please select applicable visit type Walk-In 38. If Employee Has Returned to Work, Date of return:	ML (e.g., Struck by, Fell from, Exposite the structure of the struc	31. Regular Occupation When Injure YES NO 33. Date Reported (MM/DD/YY): 35. Injured Body part(s) Description Description Primary Care Doctor visit Doctors Name Address City, State ZIP 39. Returned to Regular Duties? YES Date: NO	Did not seek medical attention Did Nodified Duties? YES Date:
32. To Whom Was Injury Reported? 34. Nature of Injury: (Burn, Fracture, Cut, E 36. Describe How Injury Occurred in DETA 37.Please select applicable visit type Walk-In 38. If Employee Has Returned to Work, Date of return:	ML (e.g., Struck by, Fell from, Exposite the structure of the struc	31. Regular Occupation When Injure YES NO 33. Date Reported (MM/DD/YY): 35. Injured Body part(s) Description Description Primary Care Doctor visit Doctors Name Address City, State ZIP 39. Returned to Regular Duties? YES Date: NO	Did not seek medical attention Did Nodified Duties? YES Date:
32. To Whom Was Injury Reported? 34. Nature of Injury: (Burn, Fracture, Cut, Ed. 1985) 36. Describe How Injury Occurred in DETA 37. Please select applicable visit type Walk-In . 38. If Employee Has Returned to Work, Date of return: 41. Preparer's Name (Please Print or Type)	ML (e.g., Struck by, Fell from, Exposite the structure of the struc	31. Regular Occupation When Injure YES NO 33. Date Reported (MM/DD/YY): 35. Injured Body part(s) Description Description Primary Care Doctor visit Doctors Name Address City, State ZIP 39. Returned to Regular Duties? YES Date: NO 42. Preparer's Title	Did not seek medical attention Did Nodified Duties? YES Date:

THIS FORM WHEN COMPLETED SHOULD BE SENT TO CITY HALL, ROOM 306, 4 SUMMER STREET, HAVERHILL, MA OR EMAILED TO hrttps://hrttps

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@cityofhaverhill.com
Christine Caminero, HR Technician – ccaminero@cityofhaverhill.com
Christina Carrie, Head Clerk/Floater – ccarrie@cityofhaverhill.com

MEDICAL AUTHORIZATION FORM

Employee:		
Claim #:		
DATE:		
TO:		
who may hav You are herek or any of its r diagnostic tes condition, dia for further tre	r physicians, hospitals, clinic or medical care provider, presently unknown to be or subsequently acquire information concerning my physical condition. by authorized to give to	rs from medica dations zed to
I am willing th the original.	hat a photostatic copy of this authorization be accepted with the same autho	ority as
	tion is to be used for the purposes of evaluating and handling my injury, and e, now or in the future."	d for no
	THIS AUTHORIZATION EXPIRES ON CONCLUSION OF THE CLAIM	
EMPLOYEE SI	GNATURE:	