FORM 101

The Commonwealth of Massachusetts
Department of Industrial Accidents - Department 101
600 Washington Street — 7th Floor, Boston, Massachusetts 02111
Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470
http://www.state.ma.us/dia

DIA USE ONLY

EMPLOYER'S FIRST REPORT OF INJURY OR FATALITY

THIS FORM MUST BE FILED BY THE *EMPLOYER* IN THE EVENT OF AN INJURY THAT RESULTS IN DEATH OR FIVE OR MORE CALENDAR DAYS OF TOTAL OR PARTIAL INCAPACITY FROM EARNING WAGES.
***INSTRUCTIONS AND CODES ON THE REVERSE SIDE* - Please Print Legibly or Type - Unreadable forms will be returned.**

EMPLOYEE

1. Employee's Name (Last, First, MI):	2. Home Telephone Number:	3. Social Security Number*:	4. Sex: ☐ M ☐ F
5. Home Address (No., Street, City, State & Zip Code):		6. Marital Status: ☐ M ☐ S	7. No. of Dependents:
8. Date of Hire (mm/dd/yyyy):	9. Date of Birth (mm/dd/yyyy):	10. Average Weekly Wage: $ ☐ Estimated ☐ Actual	

EMPLOYER

11. Employer's Name:	12. Federal Tax I.D. Number:
13. Employer's Address (No., Street, City, State & Zip Code):	14. Employer's Telephone Number:
	15. Industry Code (See Reverse Side):
16. Workers' Compensation Insurance Carrier and Tel No. (NOT LOCAL AGENT/ADMINISTRATOR): MIAI C/O AON RISK SERVICES 99 HIGH STREET, BOSTON, MA 02110	17. W.C. Policy Number:
18. Self-Insured? ☐ Yes ☐ No If Yes, Self-Insurer Number:	19. Business Type: ☐ Service ☐ Wholesale ☐ Mfg. ☐ Retail ☐ Other _____

INJURY INFORMATION

20. DATE OF INJURY (mm/dd/yyyy):	
21. Was Employee Injured on Employer's Premises? ☐ Yes ☐ No	22. Location of Injury if not on Employer's Premises:
23. FIRST day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):	24. FIFTH day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):
25. If Employee has Died, Date of Death (mm/dd/yyyy):	26. Source of Injury (Chemicals, Machinery, etc.):
27. Briefly Describe How Injury/Exposure Occurred and Body Parts(s) involved:	

28. Person to Whom Injury was Reported (list position):	29. Date Reported (mm/dd/yyyy):	30. Date reported as work related (mm/dd/yyyy):
31. Injury Code(s) / Body Part Code(s) a. to body part a. b. to body part b. c. to body part c.	32. Witness(es) to Injury - Give Full Name(s), if none state as such:	
33. Has Employee Returned to Work? ☐ Yes ☐ No	34. Date Employee Returned to Work (mm/dd/yyyy):	
35. Employee's Regular Occupation:	36. Has Employee Returned to Regular Occupation: ☐ Yes ☐ No	
37. EMPLOYER'S Name (SEE INSTRUCTIONS ON REVERSE SIDE):	38. Title:	
39. EMPLOYER'S Signature (SEE INSTRUCTIONS ON REVERSE SIDE):	40. Date Prepared (mm/dd/yyyy):	

*Disclosure of Social Security Number is Voluntary. It will aid in the processing of your report.

Form 101 - Revised 8/2001

THIS FORM DOES NOT CONSTITUTE AN EMPLOYEE'S CLAIM FOR BENEFITS UNDER WORKERS' COMPENSATION.

EMPLOYER'S FIRST REPORT OF INJURY OR FATALITY

FILING INSTRUCTIONS

WHEN TO FILE: File this form within 7 calendar days, not including Sundays and legal holidays, of receipt of notice of any injury alleged to have arisen out of and in the course of employment, which totally or partially incapacitates an employee for a period of 5 or more calendar days from earning wages. This form is not an admission of liability, but must be filed even though the Employer may believe that the Employee is not injured, or that the Employee is not entitled to benefits under M.G.L. Chapter 152.

2. WHERE TO FILE: This form should be mailed to the Department of Industrial Accidents at the address shown on the front of the form. Copies must also be provided to the Employee and to the Employer's Workers' Compensation insurer.

3. PENALTIES: Failure to report injuries on this form may result in a fine of $100.00 in accordance with M.G.L. Chapter 152, Section 6.

4. EMPLOYER'S NAME & SIGNATURE IN BOXES 37 & 39: This form must be filed by the employer or an authorized agent/representative of the employer.

INDUSTRY CODES

Agriculture, Forestry and Fishing
01 Agriculture Production - Crops
02 Agriculture Production - Livestock
07 Agricultural Services
08 Forestry
09 Fishing, Hunting and Trapping

Mining
10 Metal Mining
12 Coal Mining
13 Oil and Natural Gas
14 Nonmetallic Minerals, Except Fuels

Construction
15 General Building Contractors
16 Heavy Construction, Ex Building
17 Special Trade Contractors

Manufacturing
20 Food and Kindred Products
21 Tobacco Products
22 Textile Mill Products
23 Apparel and Other Textile Products
24 Lumber and Wood Products
25 Furniture and Fixtures
Paper and Allied Products
Printing and Publishing
28 Chemicals and Allied Products
29 Petroleum and Coal Products
30 Rubber and Misc. Plastic Products
31 Leather and Leather Products
32 Stone, Clay and Glass Products
33 Primary Metal Industries
34 Fabricated Metal Products
35 Industrial Machinery and Equipment
36 Electronic and Other Electrical Equipment
37 Transportation Equipment
38 Instruments and Related Products
39 Miscellaneous Manufacturing Industries

Transportation and Public Utilities
40 Railroad Transportation
41 Local and Interurban Passenger Transit
42 Trucking and Warehousing
43 U.S. Postal Service
44 Water Transportation
45 Transportation by Air
46 Pipelines, Except Natural Gas
47 Transportation Services
48 Communications
49 Electric, Gas and Sanitary Services

Wholesale Trade
50 Wholesale Trade - Durable Goods
51 Wholesale Trade - Non-durable Goods

Retail Trade
52 Building Materials and Garden Supplies
53 General Merchandizing
54 Food Stores
55 Automotive Dealers and Service Stations
56 Apparel and Accessory Stores
57 Furniture and Home Furnishing Stores
58 Eating and Drinking Establishments
59 Miscellaneous Retail

Finance, Insurance and Real Estate
60 Depository Institutions
61 Non-depository Institutions
62 Security and Commodity Brokers
63 Insurance Carriers
64 Insurance Agents, Brokers and Service
65 Real Estate
67 Holding and Other Investment Officers

Services
70 Hotels and Other Lodging Places
72 Personal Services
73 Business Services
75 Auto Repair Services and Parking
76 Miscellaneous Repair Services
78 Motion Pictures
79 Amusements and Recreation Services
80 Health Services
81 Legal Services
82 Educational Services
83 Social Services
84 Museums, Botanical, Zoological Gardens
86 Membership Organizations
87 Engineering and Management Services
88 Private Households
89 Services, NEC

Public Administration
91 Executive, Legislative and Garden
92 Justice, Public Order, and Safety
93 Finance, Taxation, and Monetary Benefits
94 Administration of Human Services
95 Environmental Quality and Housing
96 Administration of Economic Program
97 National Security and International Affairs

Non-classifiable Establishments
99 Non-classifiable Establishments

NATURE OF INJURY OR ILLNESS CODES

100 Amputation or Enucloation
110 Asphyxia or Strangulation, Etc.
120 Burns (Heat)
130 Burns (Chemical)
140 Concussion
160 Contusion, Crushing, Bruise
170 Cut, Laceration, Puncture
190 Dislocation
200 Electric Shock, Electrocution
210 Fracture
250 Hernia, Rupture
300 Scratches, Abrasions
310 Sprains, Strains
400 Multiple Injuries
900 No Injury
950 Damage to Prosthetic Devices
995 No Other Injury, NEC**
999 Non-classifiable

Infective or Parasitic Disease
150 Infective or Parasitic Disease, UNS*
151 Amebiasis
152 Anthrax
153 Brucellosis
154 Conjunctivitis and Opthalmia
155 Tetanus
157 Tuberculosis
159 Other Infective or Parasitic Diseases

Dermatitis
180 Dermatitis, UNS*
183 Primary Infections of the Skin
184 Other Skin Conditions
185 Dermatitis, Allergenic or Contact
189 Skin Condition, NEC**

Poisoning, Systemic
270 Poisoning, Systemic, UNS*
271 Due to Toxic Materials other than Lead
272 Diseases of the Blood and Blood Forming Organs
273 Upper Respiratory Conditions
274 Influenza, Pneumonia, Etc
276 Other Diseases of the Gastro-Intestinal Tract
278 Effects of Lead
279 Other Toxic Effects of One System Only

Respiratory Systems, Conditions of
570 Respiratory Systems, Conditions of
571 Upper Respiratory
572 Asthma, Influenza, Pneumonia

Pneumoconiosis
280 Pneumoconiosis
281 Aluminosis
282 Anthracosis
283 Asbestosis
284 Byssinosis
285 Siderosis
286 Silicosis
287 Other Pneumoconioses
289 Pneumoconioses with Tuberculosis

Nervous System, Conditions of
560 Nervous System, Conditions of - NEC
561 Diseases of the Central Nervous System
562 Diseases of the Nerves and Peripheral Ganglia

Neoplasm Tumor
550 Neoplasm Tumor UNS**
551 Malignant
552 Benign

Radiation Effects
290 Radiation Effects, UNS*
291 Non-Ionizing Radiation
292 Microwaves
293 Ionizing Radiation - X-Ray
294 Ionizing Radiation - Isotopes
295 Welder's Flash

Other
265 Carpal Tunnel Syndrome
510 Cardiovascular and Other Conditions of the Circulatory System
520 Complications Peculiar to Medical Care
500 Effects of Changes in Atmospheric Pressure
240 Effects of Environmental Heat
220 Effects of Exposure to Low Temperature
530 Eye, other Diseases of the Eye
230 Hearing Loss or Impairment
991 Heart Condition, Excludes Heart Attack
320 Hemorrhoids
330 Hepatitis, Serum and Infective
275 Hepatitis, Toxic
260 Inflammation of Joints, Etc.
540 Mental Disorders
900 No Illness
999 Non-classifiable
990 Occupational Disease, NEC**
580 Symptoms and Ill-defined Conditions

BODY PART AFFECTED CODES

Head
100 Head, UNS*
110 Brain
120 Ear(s), UNS*
121 Ear(s), External
124 Ear(s), Internal
130 Eye(s) UNS*
140 Face, UNS*
141 Jaw, Chin
144 Mouth and Throat (vocal cords, larynx)
145 Nose
Face, Multiple Parts
Face, NEC**
Scalp
160 Skull
198 Head Multiple
200 Neck & Cervical Vertebrae

UPPER EXTREMITIES
300 Upper Extremities, NEC**
310 Arm(s), UNS*
311 Upper Arm
313 Elbow(s)
315 Forearm(s)
318 Arm(s), Multiple
319 Arm(s), NEC**
320 Wrist(s)
330 Hand(s), Not Wrists or Fingers
340 Finger(s)
398 Upper Extremities, Multiple
400 Trunk, UNS*
410 Abdomen, Internal Organs, Inguinal Hernia
420 Back
430 Chest, Ribs, Breastbone, Internal Organs
440 Hip(s)...Pelvis, Organs and Buttocks
450 Shoulder(s)
498 Trunk, Multiple

LOWER EXTREMITIES
500 Lower Extremities
510 Leg(s), UNS*
513 Knee(s)
515 Lower Leg(s)
518 Leg(s), Multiple
519 Leg(s), NEC**
520 Ankle(s)
530 Foot or Feet., Not Ankle
540 Toe(s)
598 Lower Extremities, Multiple
700 MULTIPLE PARTS
Applies when more than one major body part as been effected such as an arm and a leg
999 NON-CLASSIFIABLE - Insufficient information to identify part of body effected. Includes damage to prosthetic devices.

*UNS - UNSPECIFIED

** NEC - NOT ELSEWHERE CLASSIFIED

MIIA MASSACHUSETTS BASED MEMBER DRIVEN

TOWN OF WAYLAND

SUPERVISOR'S REPORT OF ACCIDENT- INTAKE FORM

EMPLOYEE NAME_____ SOCIAL SECURITY #_____
EMPLOYEE ADDRESS_____
TELEPHONE NU:__HOME_____WORK_____
MARITAL STATUS_____DATE OF HIRE_____
DEPARTMENT_____OCCUPATION_____
DATE OF BIRTH_____ SEX(M or F)_____AVERAGE WEEKLY WAGE_____
NUMBER OF DEPENDENTS_____DATE OF INJURY_____
DESCRIPTION OF INJURY_____
LOCATION ACCIDENT OCCURRED_____
WITNESS _____WITNESS ADDRESS_____
TELEPHONE NU:_____
TO WHOM WAS INJURY REPORTED TO/THEIR POSITION_____
DID EMPLOYEE LOSE TIME FROM WORK? (Y or N)_____
FIRST DAY OF DISABILITY _____ FIFTH DAY OF DISABILITY_____
WAS MEDICAL TREATMENT SOUGHT?(Y or N)_____Tax ID Number:_____
MEDICAL FACILITY _____
DATE REPORTED A WORK RELATED:_____INJURY:_____BODY PART:_____

RETURN TO WORK DATE:_____

*******Supervisor's Complete Below**********

DESCRIPTION OF ACCIDENT; WHAT WAS EMPLOYEE DOING? WHAT HAPPENED?WHY?_____
_____

CAUSE-UNSAFE ACT OR CONDITION; OBJECT/SUBSTANCE CAUSING INJURY
_____
_____
_____

WAS EMPLOYEE WEARING SAFETY GEAR? YES_____NO_____(IF NO, EXPLAIN)
_____
_____

ACTION TAKEN TO PREVENT SIMILAR ACCIDENTS_____
REMARKS_____
_____

Investigated By_____Date_____
Reviewed By_____Date_____
☐ School Nurse ☐ Supervisor

Member Services
One Federal Street, Boston Massachusetts 02110
Toll Free (Mass) :888/266-6442
Fax: 617 753-9987

MEDICAL AUTHORIZATION

To: _____ Date:_____

_____

_____

and any other physician, hospital, 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 MIIA Member Services and/or any of its representatives, all information, facts and particulars, including reports, records, results from diagnostic tests, X-rays and statements of charges which may be requested regarding my medical condition, diagnosis, treatment and to furnish them copies of such reports. You are further authorized to allow any physicians 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 handling my claim from an occupational injury or illness occurring on or about _____ and for no other purpose, now or in the future.

This authorization is valid for the duration of the above condition.

_____ _____

(Employee's signature) (Date)

Employer:___TOWN OF WAYLAND _____

Name of Employee:_____

SS#: _____ Date of Birth: _____

Claim #:_____ Date of Accident: _____

FORM 117

The Commonwealth of Massachusetts

DEPARTMENT OF INDUSTRIAL ACCIDENTS - Department 117
600 Washington Street - 7th Floor, Boston, Massachusetts 02111

AVERAGE WEEKLY WAGE COMPUTATION SCHEDULE

PLEASE PRINT OR TYPE:

Today's Date:

Employer Name and Address	Employee #: Location #:	
Employee Name	# Children Under 18 Years Old	Dependents Other Than Children
Date of Injury (MM/DD/YY):	First Date of Disability (MM/DD/YY):	Date Employed (MM/DD/YY):
Has Employee been certified by U.S. Veterans Administration for any type of disability? ☐ Yes ☐ No		

Indicate only those wages earned by the injured employee during the 52 week period immediately preceding the accident. If the injured employee has worked less than 52 weeks, list wages for the weeks the injured employee worked.

Week No	Year: Week Ending Month / Day	Gross Amount Paid Including Overtime	No. of Meals Per Week	Week No	Year: Week Ending Month / Day	Gross	No. of Meals Per Week	Week No	Year: Week Ending Month / Day	Gross Amount Paid Including Overtime	No. of Meals Per Week
1				19				37			
2				20				38			
3				21				39			
4				22				40			
5				23				41			
6				24				42			
7				25				43			
8				26				44			
9				27				45			
10				28				46			
11				29				47			
12				30				48			
13				31				49			
14				32				50			
15				33				51			
16				34				52			
17				35							
18				36					TOTAL	0.00	

Was Room Furnished To Employee?

If Tips or Other Benefits Were Earned, Describe and State Value Per Week:

AWW
C/R
Daily

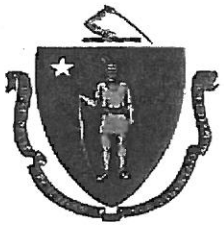
Comments

THIS IS A TRUE COPY OF THE PAYROLL RECORD OF THE ABOVE NAMED EMPLOYEE OR OF A FELLOW EMPLOEE IN THE SAME CLASS OF EMPLOYMENT.

Name of Fellow Employee:	Employer Preparer's Signature	Preparer's Title

C-21932 New 6-88 Printed in U.S.A.

NOTICE TO EMPLOYEES



NOTICE TO EMPLOYEES

The Commonwealth of Massachusetts
DEPARTMENT OF INDUSTRIAL ACCIDENTS

600 Washington Street, Boston, Massachusetts 02111
(617)-727-4900

As required by Massachusetts General Law, Chapter 152, Sections 21, 22 and 30, this will give you notice that I (we) have provided for payment to out injured employees under the above mentioned chapter by insuring with:

MIIA Property and Casualty Group, Inc.
(Name of Self-Insured Group)

One Winthrop Square, 2nd Floor, Boston, MA 02110
(Address of Self-Insured Group)

09-141
(Certificate Number)

July 1, 2009 to July 1, 2010
(Effective Dates)

MIIA, Inc.
One Winthrop Square, 2nd Floor, Boston, MA 02110 **(800) 374-4405**
(Name of Group Administrator, Address, Phone)

Town of Wayland
41 Cochituate Road
Wayland, MA 01778
(Employer, Address)

John Senchyshyn 7/1/09

Employer's Worker's Compensation Officer (If Any) (Date)

MEDICAL TREATMENT

The above named insurer is required in cases of personal injuries arising out of and in the course of employment to furnish adequate and reasonable hospital and medical services in accordance with the provisions of the Worker's Compensation Act. A copy of the First Report of Injury must be given to the injured employee. The employee must select his or her own physician. The reasonable cost of the services provided by the treating physician will be paid by insurer, if the treatment is necessary and reasonably connected to the work related injury. In cases requiring hospital attention, employees are hereby notified that the insurer has arranged for such attention at the

Fallon Clinic, 85 Lincoln Street, Framingham, MA 01701

(Name of Hospital) (Address)

TO BE POSTED BY EMPLOYER

WC 7506e (Ed. 1-89)