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 ☐ Single ☐ Married	6. No. of Dependents
7. Date of Hire (MM/DD/YY):	8. Date of Birth (MM/DD/YY):	9. Sex ☐ Male ☐ Female	10. Hourly Wage
11. Piece of Hourly Worker ☐ Piece ☐ Hourly	12. Hours Worked Per day	13. Days Worked Per Week	14. Avg. 52-Week Wage $ ☐ Estimated ☐ Actual
15. Employer Name CITY OF HAVERHILL DEPARTMENT:		16. Employer Self-Insured? ☒ YES ☐ 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 ☐ A.M. ☐ 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? ☐ YES ☐ NO	29. Employer Location Code N/A
30. Regular Occupation		31. Regular Occupation When Injured? ☐ YES ☐ 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. Please select applicable visit type:

☐ Occupational Health visit Anna Jaques Occupational Health 24 Morrill Place Amesbury, MA 01913	☐ Emergency Room visit Hospital Name: Address City State ZIP	☐ Primary Care Doctor visit Doctors Name Address City, State ZIP	☐ Did not seek medical Attention

37. Describe How Injury Occurred (e.g., Struck by___, Fell from ___, Exposed to ___...)

38. If Employee Has Returned to Work, Date of return:	39. Returned to Regular Duties? ☐ YES ☐ NO	40. Returned to Modified Duties? ☐ YES ☐ 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 DMCCLANAHAN@CITYOFHAVERHILL.COM.

_____
Principal/Dept Head/
Supervisor Initials

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

FORM UPDATED 12.07.11