



THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS - DEPARTMENT 101
600 WASHINGTON STREET - 7TH FLOOR, BOSTON, MA 02111

EMPLOYER'S FIRST REPORT OF INJURY OR FATALITY

DIA BOARD NO.:

ENTER IF KNOWN

File this form if injury has resulted in death or in 5 or more calendar days of total or partial incapacity from earning wages.

INSTRUCTIONS AND CODES ON THE REVERSE SIDE. PLEASE PRINT OR TYPE:

E M P L O Y E E	1. Employee's Name (Last, First, MI)	2. Home Telephone () -	3. Social Security Number* - -	4. Sex M <input type="checkbox"/> F <input type="checkbox"/>
	5. Home Address (No. and Street, City, State, Zip)		6. Marital Status M <input type="checkbox"/> S <input type="checkbox"/>	7. Number of Dependents
	8. Date of Hire (mm/dd/yy)	9. Date of Birth (mm/dd/yy)	10. Average Weekly Wage \$ <input type="checkbox"/> Estimated <input type="checkbox"/> Actual	
E M P L O Y E R	11. Employer's Name		12. Federal Tax I.D. Number	
	13. Employer's Address (No. and Street, City, State, Zip)		14. Employer's Telephone () -	
			15. Industry Code	
	16. Workers' Compensation Insurance Carrier (Not Local Agent/Adjuster)		17. W.C. Policy Number	
	18. Self-Insured? <input type="checkbox"/> Yes <input type="checkbox"/> No		19. Self-Insurer Number:	
R	20. Describe Nature of Business or Article Manufactured (check one) <input type="checkbox"/> Service <input type="checkbox"/> Wholesale <input type="checkbox"/> Retail <input type="checkbox"/> Manufacturing		21. Dept. No. Floor No.	
	22. Date of Injury (mm/dd/yy) / /			
I N J U R Y	23. Location Where Injury Occurred (If Different Than #13)		24. Injured on Employer's Premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Employer's Location Code		26. If Employee Has Died, Date of Death (mm/dd/yy)	
	27. First Day of Total or Partial Incapacity to Earn Wages (mm/dd/yy) / /		28. Fifth Day of Total or Partial Incapacity to Earn Wages (mm/dd/yy) / /	
I N F O R M A T I O N	29. Source of Injury (Chemicals, Machinery, Etc.)			
	30. Describe How Injury/Exposure Occurred (Struck By...Fell From...Exposed To...)			
	31. To Whom Was Injury/Death Reported? Position:		32. Date Reported (mm/dd/yy) / /	
			33. Date Reported as Work Related (mm/dd/yy) / /	
M A T E R I A L	34. Injury Code(s) a. b. c.		35. Body Part Code(s) a. b. c.	
	36. Description (Left Leg...Lower Back...)			
O T H E R	37. Witness(es) To The Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES" Please Specify.			
	38. Has Employee Returned to Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		39. Date of Return (mm/dd/yy) / /	
	40. Employee's Regular Occupation		40A. Returned to Regular Occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	41. Preparer for Employer (Please Print or Type)		42. Title	
	43. Preparer's Signature		44. Date Prepared (mm/dd/yy) / /	

*Disclosing Social Security Number is voluntary. It will assist in the processing of your report.