Massachusetts Bay Self-Insurance Group, Inc.
AIM (Accident and Injury Management) Form — Employee Injury Report

COMP 21

ACCIDENT INFORMATION

1. This portion to be completed by employer:

Employer Name: _____ Phone: _____ Fax: _____

Employee Name: _____ DOB: _____

Home address: _____

Home Phone: _____ Job Title: _____ Date of Hire: _____

Salary: _____ SS#: _____ Supervisor: _____

Date of Accident: _____ Accident Cause: _____

Accident Location: _____

Description of Accident: _____

_____

What Area of Body was Injured? _____

Names of Witnesses: _____ Date Injury Reported: _____

Has the Employee Lost Time from Work? _____ 1st Day _____ 5th Day _____

Has Employee Returned to Work? _____ Date Returned to Work: _____

Has Medical Treatment Been Sought? _____ When was 1st treatment? _____

Name and Address of Medical Provider: _____

_____ Phone Number: _____

Diagnosis: _____ Is Light Duty Available? _____

Treatment Plan: _____

Employer Signature: _____ **Date:** _____

This form must be sent to MBSIG within 24 hours of the incident
If the employee has lost more than five calendar days from work, please attach to DIA Form 101.

DOCTORS REPORT OF TREATMENT

2. This portion to be completed by Medical Provider and returned to employer:

Medical Provider Name: _____ Date of Service: _____

Address: _____

Telephone #: _____ Fax #: _____

Diagnosis: _____

Treatment plan (please include the frequency and duration of treatment):

_____

_____

_____

Next appointment (date and time): _____

EMPLOYEE WORK STATUS

Employee can return to regular duty on (date): _____ Employee can return to work on (date): _____ with restrictions noted below

Lifting, Carrying, Pushing, and Pulling Abilities

Weight:	Never	Occasional	Frequent	Continuous
1-5 lbs.				
6-10 lbs.				
11-25 lbs.				
26-40 lbs.				
41-75 lbs.				
76-100 lbs.				

Position/Activity	Never	Occasional	Frequent	Continuous
Bending				
Squatting				
Climbing				
Standing				
Walking				
Sitting				
Reaching				

Physician's signature: _____ Date: _____

Please Print Physician's Name: _____

Please fax this form to: Massachusetts Bay Self-Insurance Group, Inc. (781-376-9907)
or mail to: Massachusetts Bay Self-Insurance Group, Inc., 12 Gill Street, Suite 1600, Woburn, MA 01801 (800-222-5963)

COMP 21 Form A

White Copy: MBSIG Canary Copy: Employer Pink Copy: Employee Gold Copy: Medical Provider