



**The Commonwealth of Massachusetts**  
**Department of Industrial Accidents – Department 101**  
 600 Washington Street – 7<sup>th</sup> 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 OF FIVE OR MORE CALENDAR DAYS OF TOTAL OR PARTIAL INCAPACITY FROM EARNING WAGES.**  
*INSTRUCTIONS AND CODES ARE 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: <input type="checkbox"/> M <input type="checkbox"/> F	
	5. Home Address (No., Street, City, State & Zip Code):				6. Marital Status: <input type="checkbox"/> M <input type="checkbox"/> S		7. No. of Dependents:	
	8. Date of Hire (mm/dd/yyyy):		9. Date of Birth (mm/dd/yyyy):		10. Average Weekly Wage: \$ <input type="checkbox"/> Estimated <input type="checkbox"/> 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: (0)			
	15. Industry Code (See Reverse Side):				17. W. C. Policy Number: Loc # :			
	16. Workers' Compensation Insurance Carrier and Tel. No. (NOT LOCAL AGENT/ADMINISTRATOR): <b>MEGA Property and Casualty Group, Inc. 800-552-1150</b>				18. Self-Insured ? : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Self-Insured Number:			
INJURY INFORMATION	20. DATE OF INJURY (mm/dd/yyyy):							
	21. Was Employee Injured on Employer's Premises? <input type="checkbox"/> Yes <input type="checkbox"/> 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. In 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 Part (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? <input type="checkbox"/> Yes <input type="checkbox"/> No				34. Date Employee Returned to Work (mm/dd/yyyy):				
35. Employee's Regular Occupation:				36. Has Employee Returned to Regular Occupation: <input type="checkbox"/> Yes <input type="checkbox"/> 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.

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