



BOSTON COLLEGE ACCIDENT / INJURY REPORT FORM

NOTE: Within 24 hours after a work-related accident or injury, this report must be completed by Employee's SUPERVISOR/ MANAGER and forwarded to Risk Management, St. Clement's Hall, Room 108, Attn: Mary Magré via Fax: 617.552.3357 or email: mary.magre@bc.edu

INJURED WORKER'S STATEMENT OF ACCIDENT/INJURY			
Employee Name (Last Name, First Name):		Eagle ID #:	
Home Address:			
Home Phone:	Date of Birth:	Cell Phone:	
Job Title:		Department Name:	
Date of Injury:	Time of Accident:	Location of Injury:	
Describe how injury occurred:			
Were you ever treated for a similar condition before:		Body Part(s) Injured:	
If yes, give details:			

SUPERVISOR'S/ MANAGER'S STATEMENT	
Injury:	
Did injured worker receive medical treatment:	
Object or machinery causing injury:	
Name and phone number of witnesses (if any):	
Did injured worker lose time from work:	If yes, first full day of disability:
Has the injured worker returned to work:	If yes, date returned:
Supervisor's Name:	Phone ext:
Date:	

AUTHORIZATION TO RELEASE INFORMATION
<p>I hereby authorize Boston College, and/ or Cannon Cochran Management Services Inc. (CCMSI), or any of its representatives to be furnished any information and facts regarding medical services rendered to me by any medical provider, including reports/ records, results of diagnosis, treatment and prognosis, estimates of disability and recommendations for further treatment. This information is to be used for the purpose of evaluating and handling my claim for injury as a result of an incident occurring on or about the above indicated date of injury and for no other purpose, now or in the future.</p> <p>Copies and facsimiles of this authorization shall be effective and valid.</p> <p>This authorization expires on life of claim.</p>
<p>Employee Signature: _____ Date: _____</p>

If you have any questions regarding the completing of this form, contact Mary Magré at X2-2040.