



**Lowell Public Schools  
INJURY / ACCIDENT REPORTING PROCEDURE**

1. Employee must notify their direct supervisor immediately.
2. Employee must complete an Employee Injury Report Form immediately following the accident/injury unless totally incapacitated.
3. Supervisor will investigate accident/injury and ensure that the employee takes the appropriate action indicated in this procedure.
4. Supervisor must complete PART B of the Employee Injury Report Form immediately following accident/injury of the employee.
5. Supervisor must email/fax notification of accident or injury to the City of Lowell Law Department, to the Lowell Public Schools Office of Human Resources at 978-674-2143, and to the UTL at 978-937-9544.
6. If immediate medical attention or treatment is required due to life threatening injury, call 911 and or report to the nearest emergency room. Reports from the hospital emergency room must be submitted to the Lowell Public Schools Office of Human Resources and the City of Lowell Law Department within 48 hours.
7. Non life threatening injuries must be evaluated immediately at LGH Walk-in Center, 10 Research Place, North Chelmsford, MA 01824 (978-458-6868) or LGH Walk-In Center, 1230 Bridge Street, Lowell, MA 01850 (978-459-2273).
8. Please be advised that emergency medical treatment does not include physical therapy, occupational therapy, chiropractic treatment or other rehabilitation treatment. Any injured employee seeking medical treatment other than emergency treatment must first be approved by the City of Lowell Law Department.
9. Supervisors must conduct a complete investigation of the alleged work related injury, documenting any witnesses and their account of the incident. The supervisor should also forward any other pertinent information regarding an injury to the Lowell Public Schools Office of Human Resources and the City of Lowell Law Department.
10. If First Aid is administered by a School Nurse, the Nurse must complete SOAP notes.

**If you have any question or need assistance regarding this procedure, please do not hesitate to contact:**

**Karen A. Gagnon, Workers' Compensation/Claims Agent**  
City of Lowell Law Department  
Tel: 978-674-1503  
Fax: 978-453-1510  
Email: [kgagnon@lowellma.gov](mailto:kgagnon@lowellma.gov)

**Lowell Public Schools Office of Human Resources**  
Tel: 978-674-4327



**CITY OF LOWELL PUBLIC SCHOOLS  
EMPLOYEE INJURY REPORT FORM**

(for reporting work-related injuries)

**PLEASE PRINT THE REQUIRED INFORMATION**

This report must be completed immediately by the Injured Employee and his Supervisor. This form must be forwarded to the Law Department and your Human Resource Department **WITHIN 24 HOURS** of any on-the-job injury.

Date of this report: \_\_\_/\_\_\_/\_\_\_ (mm/dd/yyyy) Are you expected to miss time out of work? \_\_\_\_\_

CHECK TREATMENT: \_\_\_ First Aid Only \_\_\_ Health Facility \_\_\_ Hospital

If First Aid is administered by the SCHOOL NURSE, the NURSE MUST COMPLETET PART C.

If injured employee was sent to a Health Care Facility or Hospital, please state the name of the facility:

**PART A: INJURED WORKER'S STATEMENT OF ACCIDENT/ILLNESS**

Employee Name (Last Name, First Name):	Employee Number:
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Home address:	Home phone	Cell Phone	Email Address
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Date of Hire:	Date of Birth:	Hourly Wage: \$
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Department Name:	Job Title/Current Position and Location:
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Date of Injury:	Time of injury: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Specific location where injury occurred:
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How did injury happen: Attach additional paperwork if more space needed.	Regular Start Time: _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Regular End Time: _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
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Were you ever treated for a similar condition before:  
 Yes  No      If yes, give details:

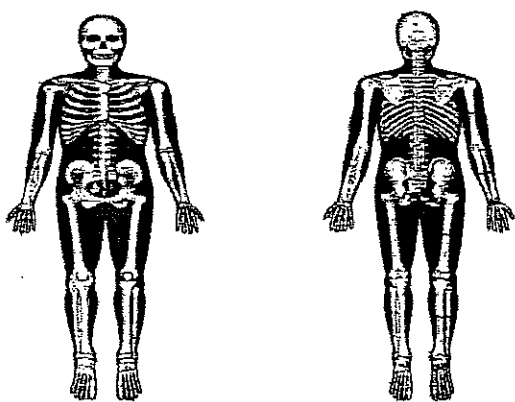
**AUTHORIZATION TO OBTAIN MEDICAL INFORMATION**

I, \_\_\_\_\_, authorize any attending physician, hospital, or other health professional and or medical provider to release and exchange information to the City of Lowell Law Dept. that is pertinent to the accident/injury/illness I incurred while at work on \_\_\_/\_\_\_/\_\_\_ (date of injury). This consent form shall be in effect for the duration of my workers' compensation claim and without limitation.

I am willing that a photocopy of this authorization be accepted with same authority as an original.

Body part(s) injured: Please state specifically:  
\_\_\_\_\_

Please circle the appropriate injured body part below:



\_\_\_\_\_  
Employee's Signature

I declare that the above statements are true under the pains and penalties of perjury.

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PART B: SUPERVISOR'S STATEMENT**

Date Injury was reported to you:		Location of Injury:	
Did injured worker receive medical treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain why:	Date employee sought treatment.	Name and address of hospital or physician:	
Object or machinery causing injury:			
Was there contact with any other person's blood or body fluid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name and address of source person:			
Causes: what causes, failures to act or conditions contributed directly to the accident?		Did weather conditions contribute to occurrence: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what were the weather conditions:	
How could a similar occurrence be avoided:		Describe any unsafe practice:	
Action Plan: What will be done to prevent similar loss?			
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:	

I declare that the above statements are true under the pains and penalties of perjury.

Supervisor's Name:		Signature:	
Phone ext:		Date Completed:	
<p>If the injured worker returns to work or becomes disabled after this form has been filed, it is imperative that the Law Department is notified IMMEDIATELY.</p> <p><u>Part A</u> is to be completed by the injured employee immediately after he/she has reported any on the job injury to his/her supervisor. All questions must be answered. The employee's signature is required.</p> <p><u>Part A</u> is to be verified by the Supervisor.</p> <p><u>Part B</u> is to be completed and signed by the supervisor. Discuss the occurrence in detail with the injured worker prior to completing this section. If you have any valid reason to believe the occurrence did not happen as described, use the word "Alleged" in your description of injury.</p> <p><u>Part C</u> is to be completed by School Nurse and only if first aid is administered by School Nurse.</p> <p>If you have any questions regarding the filing of this form, contact the City of Lowell Law Department.</p> <p><b>Original and three copies of the Workers' Compensation Injury Form are needed.</b></p> <p>1. Original to: City of Lowell Law Dept. / Workers' Compensation/Claims Agent 375 Merrimack Street, 3<sup>rd</sup> Floor, Lowell, MA 01852 Phone: 978-674-4058 Fax: 978-453-1510</p> <p>2. Copy to be retained with your department.</p> <p>3. Copy to be forwarded to Human Relations Office.</p> <p>4. Copy to be forwarded to your Retirement Board.</p> <p>5. Copy to be faxed to Lowell Public Schools Human Resources 978-674-2143</p> <p>6. Copy to be faxed to United Teachers of Lowell 978-937-9544.</p> <p style="text-align: center;"><b>IT IS YOUR RESPONSIBILITY TO FILE YOUR REPORT TO THE ABOVE LOCATIONS.</b></p>			



CITY OF LOWELL  
EMPLOYEE INJURY REPORT FORM

If First Aid is administered by the SCHOOL NURSE, the NURSE MUST COMPLETE PART C.

PART C: REQUIRED ATTENDING NURSE'S NOTES	
Employee Name (Last Name, First Name):	Employee Number:

S: \_\_\_\_\_

O: \_\_\_\_\_

A: \_\_\_\_\_

P: \_\_\_\_\_

I declare that the above statements are true under the pains and penalties of perjury.

Attending Nurse's Signature \_\_\_\_\_

Date: \_\_\_\_\_

In the event that first aid is administered by the school nurse, this form must be filled out completely and submitted along with Employee's Injury Report Form.