FORM 101

The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 101
1 Congress Street, Suite 100, Boston, Massachusetts 02114-2017
Info. Line 800-323-3249 ext. 7470 in Mass. Outside Mass.- 617-727-4900 ext. 7470
http://www.mass.gov/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 OR FIVE OR MORE CALENDAR DAYS OF TOTAL OR PARTIAL INCAPACITY FROM EARNING WAGES.
***INSTRUCTIONS AND CODES 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: ☐ M ☐ F
5. Home Address (No., Street, City, State & Zip Code):	5a. Native Language Code: Other:	6. Marital Status: ☐ M ☐ S	7. No. of Dependents:
8. Date of Hire (mm/dd/yyyy):	9. Date of Birth (mm/dd/yyyy):	10. Average Weekly Wage: ☐ Estimated ☐ 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:
	15. Industry Code (See Reverse Side):
16. Workers' Compensation Insurance Carrier and Tel. No. (NOT LOCAL AGENT/ADMINISTRATOR): **Acadia Insurance Company 508-786-6600**	17. W.C. Policy Number:
18. Self-Insured? ☐ Yes ☐ No If Yes, Self-Insurer Number:	19. Business Type: ☐ Service ☐ Wholesale ☐ Mfg. ☐ Retail ☐ Other _____

INJURY INFORMATION

20. DATE OF INJURY (mm/dd/yyyy):	**20a. Insurer's Case/Claim File No.:**
21. Was Employee Injured on Employer's premises? ☐ Yes ☐ 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. If 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? ☐ Yes ☐ No	34. Date of Employee Returned to Work (mm/dd/yyyy):	
35. Employee's Regular Occupation:	36. Has Employee Returned to Regular Occupation: ☐ Yes ☐ No	

PREPARER

37. PREPARER'S Name (SEE INSTRUCTIONS ON REVERSE SIDE):	38. PREPARER's Title:	
39. PREPARER'S Signature (SEE INSTRUCTIONS ON REVERSE SIDE):	40. Date Prepared (mm/dd/yyyy):	40a. PREPARER's e-mail address:

*Disclosure of Social Security Number is Voluntary. It will aid in the processing of your report. Form 101 – Revised 7/2013 – Reproduce as needed.

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