Guardian Claims Services, Inc.
P.O. Box (B)
Kingston, MA 02364
Tel: (508) 342-1688
Fax: (508) 342-2689

DENNIS YARMOUTH RSD

WORKERS' COMPENSATION INCIDENT REPORT FORM

General Instructions:

- This report must be filled out completely by the injured employee.
- This report must be signed by the employee and the employee's supervisor.
- Once the report is completed, please email it as soon as possible to the claims adjuster listed below:

  - Claims Adjuster: James Patrick
  - Email: jpatrick@guardianclaimsservices.com

EMPLOYEE INFORMATION			
Employer Name:		Male: ☐	Female: ☐
Employee Name: Last:		First:	
Home Address:			
Personal Phone #:		Email:	
DOB:		SS#:	
Date of Injury:		Time of Injury:	
ACCIDENT INFORMATION			
Location of Accident:		Witness Name:	
Type of Injury/Illness:			
Body Part Affected:			
Description of Accident:			
Was medical attention sought:		Date seen:	
Medical Provider:			
Physician's Name:		Phone Number:	
SIGNATURES			
Employee Signature:		Date:	
Supervisor Signature:		Date:	

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WORKERS COMPENSATION
SUPERVISORS INVESTIGATION REPORT

EMPLOYEE INFORMATION	
Employee Name: Last:	First:
Male: ☐ Female: ☐	DOB:
SS#:	Employee Dept:
Date of Injury:	Time of Injury:
When were you informed or made aware that this employee suffered an injury?	
How were you informed or made aware that this employee suffered an injury?	
What were told regarding this injury?	
What part of the employee's body was reported as injured to you?	
Did the employee seek medical attention? If so, where?	
Where there any delays in the employee reporting this injury? If so, please explain reason?	
Additional information that may be beneficial in the review of this claim	
Supervisor Signature:	Date:

MEDICAL AUTHORIZATION FORM

EMPLOYEE:_____

CLAIM #:_____

TO:_____ **DATE:**_____

_____

_____

and any other physicians, hospitals, clinic or medical care provider, presently unknown to me, who may have or subsequently acquire information concerning my physical condition.

You are hereby authorized to give to **Guardian Claims Services, Inc.**, or any of its representatives, all information, facts and particulars, including reports, records, results from diagnostic tests, x-rays and statements of charges which may be requested regarding my medical condition, diagnosis, treatment rendered, prognosis, estimates of disability or recommendations for further treatment and to furnish them copies of such reports. You are further authorized to allow any physician appointed by them to review all such reports, records and x-rays in your possession.

I am willing that a photostatic copy of this authorization be accepted with the same authority as the original.

This information is to be used for purposes of evaluating and handling my work related injury, and for no other purpose, now or in the future.

THIS AUTHORIZATION EXPIRES ON CONCLUSION OF CLAIM.

SIGNATURE:_____

Work Related Injury
Witness Statement

Witness Name	Witness Job Title
Witness Department	Witness Supervisor
Accident Date	Accident Time
Accident Site	Party Claiming Injury
Any Visible Injury Noticed	Work Being Performed During Incident

State Your Account of the Incident: