



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: <input type="checkbox"/> M <input type="checkbox"/> F
	5. Home Address (No., Street, City, State & Zip Code):	5a. Native Language Code: Other:	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:	
			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? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Self-Insurer Number:		19. Business Type: <input type="checkbox"/> Service <input type="checkbox"/> Wholesale <input type="checkbox"/> Mfg. <input type="checkbox"/> Retail <input type="checkbox"/> 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? <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. 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	34. Date of 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			
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.