ATLANTIC CHARTER
INSURANCE COMPANY

25 New Chardon St • Boston, MA 02114-4721 • Phone: (617) 488-6500 • Fax: (617) 488-6502

EMPLOYEE INCIDENT REPORT
This Report Must Be Sent To Administration Within 24 Hours of Incident

☐ **File Only** ☐ **Medical Only (3 or Less Calendar Days)** ☐ **Lost Time (More Than 3 Calendar Days)**

Also complete Employer's First Report of Alleged Occupational Injury, Disease or Fatality

EMPLOYER'S NAME:	**PHONE:**
ADDRESS:	**FEIN:**

I. SUPERVISORY REPORT

Name of Employee	Job Title	Date of Birth	Social Security Number

Home Address (Street, City, ZipCode)	Home Phone Number ( )

Date of Incident	Time	( ) AM ( ) PM	Department/Shift	Date of Hire

Location of Incident (Street, City, ZipCode)			
Who was first notified of Incident?			Date & Time
Name of Witness(es)			
Did Employee Require Medical Attention? If yes: Physician or Hospital Name and Address:	Yes ( )	No ( )	Date of Initial Treatment:
Any Lost-Time from Work?	Yes ( )	No ( )	Date Last Worked:
Has Employee returned to Work?	Yes ( )	No ( )	Date:
Name of Person Preparing Report:			Title:
Signature:			Date:

I. EMPLOYEE'S STATEMENT

Describe the Incident in Detail:

Part of Body Injured (Be Specific: Right or Left, etc.):

Employee Signature:	**Date:**

III. ➢ EMPLOYEE'S MEDICAL AUTHORIZATION ➢ **(REQUIRED)**

I authorize the release of all medical information without limitation, including, but not limited to, history, findings, diagnosis, prognosis and access to all treatment records for examination and photocopying to Charter Management Company, Inc., Atlantic Charter Insurance Company and Sallop and Weisman P.C.I authorize that a photocopy of this form be accepted with the same authority as the original. Please be advised that pursuant to 45 CFR 164.512(l), the HIPAA Privacy Rule does not apply to entities that are either workers' compensation insurers, workers' compensation administrative agencies or employers. The Privacy Rule recognizes the legitimate need of insurers and other entities involved in the workers' compensation system to have access to an individual's health information as authorized by state or other law.

Employee Signature:	**Date:**