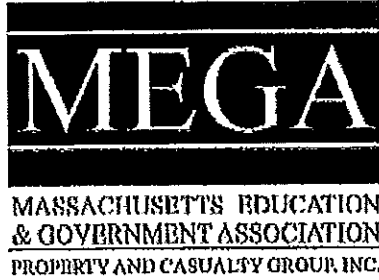


**Cape Cod Collaborative**  
Osterville Campus  
418 Bumps River Road  
Osterville, MA 02655



**MEDICAL ONLY NOTICE OF INJURY**

*If employee is disabled for 5 or more days, please complete First Report of Injury - Form 101*

Employer: **Cape Cod Collaborative** MEGA Location #: **X34**

Employee's Name \_\_\_\_\_ DOB: \_\_\_\_\_

Address \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Department \_\_\_\_\_ Job Title \_\_\_\_\_ DOH: \_\_\_\_\_

Rate of Pay: \_\_\_\_\_ Date of Incident \_\_\_/\_\_\_/\_\_\_ Time \_\_\_\_\_

Location \_\_\_\_\_ Body Part \_\_\_\_\_

Type of Injury (strain, laceration, etc) \_\_\_\_\_

Describe what happened \_\_\_\_\_

Name of Witness(es) \_\_\_\_\_

To whom was accident/incident reported to? \_\_\_\_\_ Date Reported \_\_\_\_\_

Was medical attention sought? Yes \_\_\_ No \_\_\_ If yes, Where? \_\_\_\_\_

**Information Release**

I hereby authorize Massachusetts Education and Government Association Property & Casualty Group, Inc. (MEGA), or any of its representatives to be furnished any information and facts regarding medical services rendered to me by any medical provider, including reports/records, results of diagnosis, treatment and prognosis, estimates of disability and recommendations for further treatment. This information is to be used for the purpose of evaluating and handling my claim for injury as a result of an incident occurring on or about the above indicated date of injury and for no other purpose, now or in the future.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Supervisor Comments \_\_\_\_\_

Supervisor Signature \_\_\_\_\_ Date \_\_\_\_\_

Please mail or fax completed form:

100 Quannapowitt Parkway, Suite 201 Wakefield, MA 01880  
Phone: 781-683-1000 Fax: 781-246-3425