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

TOWN OF STOUGHTON

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.
- To avoid claim processing delays, once report is completed please provide a copy as soon as possible to the following:

o Guardian Claims Services, Inc., Attention Susan Carey: Fax (508) 342-1689 or email to scarey@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: