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

TOWN OF STOUGHTON

WORKERS COMPENSATION
SUPERVISORS INVESTIGATION REPORT

- This report must be filled out completely and signed by the injured employee's supervisor:
- To avoid claim processing delays, once the report is completed please provide a copy to the following:
- Guardian Claims Services, Inc., Attention Susan Carey: Fax (508) 342-1689 email: scarey@guardianclaimsservices.com

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: