

## NOTICE TO EMPLOYEES

## THE COMMONWEALTH OF MASSACHUSETTS DEPARTMENT OF INDUSTRIAL ACCIDENTS



## **IF YOU ARE INJURED ON THE JOB:**

• Immediately notify	your employer	that you hav	e been injured.		
Employer HR/Workers' Com	pensation Contact		Phone Number		
• Tell the medical pro	vider that you h	nave been inj	ured at work an	d give the information be	elow:
Insurance Carrier		Address		Phone Number	
Employer		Address			
• If the employer fails Claim (Form 110).	to report the i	njury to the i	nsurer, the emp	oloyee may file an Employ	/ee's
	nay be obtaine	d by contact		benefits pursuant the Wo nent of Industrial Accider	
Injured workers may	IF MEDIC	AL TREAT	-	EDED: cal treatment costs that paid by the above-name	
If medical facility in has a preferred prointial treatment at:		-			
Medical Facility:	Address:				
Phone Number:					

EMPLOYER: THIS NOTICE MUST BE FILLED OUT AND POSTED WHERE EMPLOYEES CAN READ IT PURSUANT M.G.L. C. 152, SECTIONS 21, 22, 30, AND 75B (2). EMPLOYERS MAY NOT RETALIATE, DISCRIMINATE (IN ACCORDANCE WITH ANY APPLICABLE STATE OR FEDERAL LAWS WHICH INCLUDES IMMIGRATION STATUS), OR PROVIDE FALSE INFORMATION ABOUT THE WORKERS' COMPENSATION PROCESS TO THEIR EMPLOYEES. THIS NOTICE MUST BE UPDATED, POSTED AND REDISTRIBUTED WHEN THERE ARE CHANGES TO THE INFORMATION.