A.I.M. Mutual
INSURANCE COMPANIES

MEDICAL ONLY / MED FAX REPORT

Fax this report to A.I.M. Mutual Ins. Cos. at 781-270-5599
Tel. No. 1-800-876-2765

DO NOT File This Form With The Dept. of Industrial Accidents
MedFax Rev. 3/11

SECTION A — SUPERVISOR

Employee Name (Last, First, MI):		Employee Telephone: ( ) -	Social Security Number: -- --
Employee Address:		Sex: ( ) F ( ) M	Date of Birth: / /
Insurer: ☐ **A.I.M. Mutual** ☐ **MEIC** ☐ **AEIC** ☐ **NH Employers PO Box 4070, Burlington, MA 01803-0970**	Location Code:		Marital Status: ( ) Single ( ) Married
Employer:		Employer Telephone: ( ) -	Policy Number:
Employee Occupation:	Witness to Accident:	Date of incident: / /	Time of incident: ( )AM ( )PM
Date of hire: / /	Date assigned to present position: / /	Date incident reported: / /	To Whom: / Returned to work: ( ) Yes ( ) No
Address where injury occurred (If different from Employer above):		Date of Return to Work: / /	Returned to Regular Job: ( ) Yes ( ) No
Type of injury (Burn, Fracture, Cut, etc.):		Average 52 Week Wage: $ ( ) Estimated ( ) Actual	
Injured Body Part(s) (Arm, Leg, Back, etc.):	Source of injury (Chemicals, Machinery, etc.):	Name of Employer's Claim Coordinator:	
Height: ft. in.	Weight:	Smoker: ( ) Yes ( ) No If yes, # pack(s) per day:	
Describe what happened:			

Supervisor Signature: _____ Date:_____/_____/_____

SECTION B

Medical Authorization: In accordance with state law, I, the undersigned, authorize A.I.M. Mutual Insurance Companies, as a workers compensation insurer, and its authorized agents or representatives, as well as my employer to be furnished with any information or facts regarding this injury only, including records, diagnosis, medical treatment and prognosis, estimates of disability and recommendations for further treatment. This information is to be used for the sole purpose of evaluating and handling my claim and to assure timely medical care as a result of the incident occurring on or about the above noted date and for no other purpose, now or in the future. I also agree that a photocopy of this release is as valid as the original.

Employee Signature: _____ Date: _____/_____/_____

I do not want medical treatment for this injury – Employee Signature: Date: / /

SECTION C — MEDICAL PROVIDER

TREATMENT AREA USE ONLY **(To be filled out by Medical Care Provider)**

Name of Provider: _____ Date: ____/____/____ Arrival Time: _____ ( )AM ( )PM

Accident Description: _____

Preliminary Diagnosis: _____ New Injury/Illness: ( )Yes( )No

Related to above incident at work: ( )Yes ( )No ( )Undetermined Pre-existing Condition: ( )Yes ( )No

Height: ____ ft. __ in Weight:_____lbs. Smoker: ( ) Yes ( ) No If yes, # pack(s) per day _____

Recommended Work Status: (Check one and provide additional information as appropriate)

Full Duty ( ) Modified Duty ( )

Full Duty to resume on: _____/_____/_____ Unable To Immediately Return To Work ( )

Modified duty to begin: _____/_____/_____ Full Duty to resume on: _____/_____/_____

May lift up to:	5 lbs. ( )	25 lbs. ( )	40 lbs. ( )	75 lbs. ( )	No lifting	( )
May carry up to:	5 lbs. ( )	25 lbs. ( )	40 lbs. ( )	75 lbs. ( )	No carrying	( )
May Push/Pull up to:	5 lbs. ( )	25 lbs. ( )	40 lbs. ( )	75 lbs. ( )	No pushing/pulling	( )

Other Duty Modifications: _____

Physician Comments: _____

Follow-Up Appointment With: _____ Date: ____/____/____ Time: _____ ( ) AM ( ) PM

Physician/Clinician Name:_____ Tel. #: ( ) _____ - _____
(Please print legibly)

Physician/Clinician Signature: _____ Date: _____/_____/_____

SUPERVISOR ACTION: ( ) Returned to Work ( ) Modified Duty ( ) Send Home ( ) Send for Treatment
( ) Notice Only ( ) Medical Only ( ) Lost Industry Code: _____ (see Instruction sheet)

All work–related incidents are to be promptly reported to the immediate department supervisor on duty who will complete this form.

EMERGENCIES

In life–threatening situations, seek medical attention immediately; then proceed with completion of this form.

NON-EMERGENCIES

SUPERVISOR - Complete **SUPERVISOR SECTION** (top portion) upon report of injury. If medical attention is refused or not needed, complete **SUPERVISOR ACTION** section, (bottom of form) and send all copies to Human Resources office.

EMPLOYEE - Sign the **AUTHORIZATION** section. If you do **not** want medical treatment; also sign the next section indicating you do not wish to have medical treatment.

PHYSICIAN - Complete the **MEDICAL TREATMENT SECTION** and sign. Keep a copy.

When outside medical attention is needed, employee is escorted to appropriate treatment site with THREE copies of the Medical Only/Med Fax Report. One copy is for the Employee. The second copy is for the Physician and the final copy should be sent to Human Resources.

A.I.M. Mutual Insurance Cos.
Immediate Care Facility

_____

_____

_____

AFTER IMMEDIATE CARE RENDERED

EMPLOYEE - Return to supervisor following treatment with completed Reports and keep a copy.

SUPERVISOR - Based on medical instructions (**MEDICAL TREATMENT** section) employee will return to work on full or modified duty, or be sent home.

- Forward the completed Medical Only/Med Fax Report to A.I.M. Mutual Ins. Cos. within 24 hours.

INDUSTRY CODES

Agriculture, Forestry and Fishing
01 Agriculture Production - Crops
02 Agriculture Production - Livestock
03 Agriculture Services
04 Forestry
05 Fishing, Hunting and Trapping
Mining
10 Metal Mining
12 Coal Mining
13 Oil and Gas Extraction
14 Nonmetallic Minerals, Except Fuels
Construction
15 General Building Contractors
16 Heavy Construction, Ex. Building
17 Special Trade Contractors
Manufacturing
20 Food and Kindred Productions
21 Tobacco Products
22 Textile Mill Products
23 Apparel and Other Textile Products
24 Lumber and Wood Products
25 Furniture and Fixtures
26 Paper and Allied Products
27 Printing and Publishing
28 Chemicals and Allied Products
29 Petroleum and Coal Products
30 Rubber and Misc. Plastics Products
31 Leather and Leather Products
32 Stone, Clay and Glass Products
33 Primary Metal Industries
34 Fabricated Metal Products
35 Industrial Machinery and Equipment
36 Electronic and Other Electric Equipment
37 Transportation Equipment
38 Instruments and Related Products
39 Miscellaneous Manufacturing Industries
Transportation and Public Utilities
40 Railroad Transportation
41 Local and Interurban Passenger Transit
42 Trucking and Warehousing
43 U.S. Postal Service
44 Water Transportation
45 Transportation by Air
46 Pipelines, Except Natural Gas
47 Transportation Services
48 Communications
49 Electric Gas and Sanitary Services
Wholesale Trade
50 Wholesale Trade – Durable Goods
51 Wholesale Trade – Nondurable Goods
Retail Trade
52 Building Materials and Garden Supplies
53 General Merchandising Stores
54 Food Stores
55 Automotive Dealers and Service Stations
56 Apparel and Accessory Stores
57 Furniture and Homefurnishing Stores
58 Eating and Drinking Places
59 Miscellaneous Retail
Finance, Insurance and Real Estate
60 Depository Institutions
61 Nondepository Institutions
62 Security and Commodity Brokers
63 Insurance Carriers
64 Insurance Agents, Brokers and Service
65 Real Estate
67 Holding and Other Investment Offices
Services
70 Hotels and Other Lodging Places
72 Personal Services
73 Business Services
75 Auto Repair Services and Parking
76 Miscellaneous Repair Services
78 Motion Pictures
79 Amusement and Recreation Services
80 Health Services
81 Legal Services
82 Educational Services
83 Social Services
84 Museums, Botanical, Zoological Gardens
86 Membership Organizations
87 Engineering and Management Services
88 Private Households
89 Services, NEC
Public Administration
91 Executive, Legislative and Garden
92 Justice, Public Order and Safety
93 Finance, Taxation and Monetary Policy
94 Administration of Human Resources
95 Environmental Quality and Housing
96 Administration of Economic Programs
97 National Security and International Affairs
Nonclassifiable Establishments
99 Nonclassifiable Establishments