WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

GENERAL

EMPLOYER (NAME & ADDRESS INCL. ZIP)

CARRIER/ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE

JURISDICTION

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)

LOCATION #

SIC CODE

EMPLOYER FEIN

PHONE #

CARRIERS / CLAIMS ADMIN

CARRIER (NAME, ADDRESS & PHONE NO)

POLICY PERIOD

TO

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CHECK IF APPROPRIATE

☐ SELF INSURANCE

CARRIER FEIN

POLICY / SELF-INSURED NUMBER

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE

NAME (LAST, FIRST, MIDDLE)

DATE OF BIRTH

SOCIAL SECURITY NUMBER

DATE HIRED

STATE OF HIRE

ADDRESS (INCL ZIP)

SEX

☐ MALE

☐ FEMALE

☐ UNKNOWN

MARITAL STATUS

☐ UNMARRIED SINGLE/DIVORCED

☐ MARRIED

☐ SEPARATED

☐ UNKNOWN

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

TELEPHONE (INCLUDE AREA CODE)

OF DEPENDENTS

NCCI CLASS CODE

WAGE

RATE

PER:

☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER:

DAYS WORKED/WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM

DATE OF INJURY /ILLNESS

TIME OF OCCURRENCE ☐ AM ☐ PM

LAST WORK DATE

DATE EMPLOYER NOTIFIED

DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER

TYPE OF INJURY/ILLNESS

PART OF BODY AFFECTED

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES ☐ YES ☐ NO

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIALS OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS / ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

TREATMENT

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS

HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT

0	NO MEDICAL TREATMENT
1	MINOR: BY EMPLOYER
2	MINOR CLINIC/HOSP
3	EMERGENCY CARE
4	HOSPITALIZED > 24HRS
5	FUTURE MAJOR MEDICAL/ LOSS TIME ANTICIPATED

OTHER

WITNESS (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE

PHONE NUMBER

NOTICE

This form is NOT a claim for compensation. Failure to file a claim within 2 years of the date of accidental injury may bar an employee's claim for compensation. Employees may obtain claim forms from the Worker' Compensation Commission.

EMPLOYER:

COMPLETE BOTH SIDES OF THIS FORM AND SEND IT IMMEDIATELY TO --

WORKERS' COMPENSATION COMMISSION
10 EAST BALTIMORE STREET, BALTIMORE, MARYLAND 21202-1641

A copy of this form must be mailed to the DIVISION OF LABOR AND INDUSTRY, 1100 N. EUTAW STREET, SUITE 611 BALTIMORE, MARYLAND, 21201 and an additional copy should be sent by the employer to his or her workers' compensation insurance carrier. The weekly earnings schedule below of the employee whose injury is being reported on the front side of this form should be completed at the time the report is submitted if at all possible, but in any event the wage information must be supplied no later than ten (10) days following the employer's receipt of a Notice of Claim from the Commission. An employer's failure to submit the wage information as required will result in the Commission's use of information supplied by the Claimant to the possible detriment of the employer.

REPORT OF WAGE INFORMATION

Injured Employee Name **Social Security Number**

Week No.	*Week Ending* *Month*	*Day*	*Year*	*Days Worked*	**Gross**	*Amount Paid Including all Overtime*
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						

Was this employee given free rent, lodging, board, tips or other allowances in addition to the above earnings? If yes state weekly value thereof. $ _____

Signed _____

(MD Supp Rev 12/97)

SUBMIT FORM