

WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

		EMPLOYER (NAME & ADDRESS INCL ZIP)				CARRIER / ADMINISTRATOR CLAIM NUMBER				REPORT PURPOSE CODE		
G E N E R A L					JURISDICTION		JURISDICTION CLAIM NUMBER					
					INSURED REPORT NUMBER							
					EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)			LOCATION #				
		SIC CODE		EMPLOYER FEIN						PHONE #		
C L A I M S	CARRIER (NAME, ADDRESS & PHONE NO)				POLICY PERIOD		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)					
					TO							
					CHECK IF APPROPRIATE							
					<input type="checkbox"/> SELF INSURANCE							
A D M I N	CARRIER FEIN		POLICY / SELF-INSURED NUMBER				ADMINISTRATOR FEIN					
	AGENT NAME & CODE NUMBER											
E M P L O Y E E	NAME (LAST, FIRST, MIDDLE)				DATE OF BIRTH		SOCIAL SECURITY NUMBER		DATE HIRED		STATE OF HIRE	
	ADDRESS (INCLZIP)				SEX		MARITAL STATUS		OCCUPATION / JOB TITLE			
					M MALE		U UNMARRIED SINGLE/DIVORCED					
					F FEMALE		M MARRIED		EMPLOYMENT STATUS			
					U UNKNOWN		S SEPARATED					
	TELEPHONE (INCLUDE AREA CODE)				# OF DEPENDENTS		K UNKNOWN		NCCI CLASS CODE			
W A G E	RATE		PER:		DAY		MONTH		# DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY?	
					WEEK		OTHER:				DID SALARY CONTINUE?	
O C C U R R E N C E	TIME EMPLOYEE BEGAN WORK		AM		DATE OF INJURY / ILLNESS		TIME OF OCCURRENCE		AM		LAST WORK DATE	
			PM						PM		DATE EMPLOYER NOTIFIED	
		CONTACT NAME / PHONE NUMBER				TYPE OF INJURY / ILLNESS				PART OF BODY AFFECTED		
		DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES?				TYPE OF INJURY / ILLNESS CODE				PART OF BODY AFFECTED CODE		
		<input type="checkbox"/> YES <input type="checkbox"/> NO										
O C C U R R E N C E	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							
E	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 RETURNED TO WORK		IF FATAL, GIVE DATE OF DEATH		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?		<input type="checkbox"/> YES <input type="checkbox"/> NO				
						WERE THEY USED?		<input type="checkbox"/> YES <input type="checkbox"/> NO				
T R E A T M E N T	PHYSICIAN / HEALTH CARE PROVIDER (NAME & ADDRESS)				HOSPITAL (NAME & ADDRESS)				INITIAL TREATMENT			
									0 NO MEDICAL TREATMENT			
									1 MINOR: BY EMPLOYER			
									2 MINOR CLINIC/HOSPITAL			
									3 EMERGENCY CARE			
O T H E R	WITNESSES (NAME & PHONE #)								4 HOSPITALIZED > 24 HRS			
									5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED			
		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 Workers' Compensation Commission.

EMPLOYER:

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

WORKERS' COMPENSATION COMMISSION
6 NORTH LIBERTY STREET, BALTIMORE, MARYLAND 21201-3785

A copy of this form must be mailed to the DIVISION OF LABOR AND INDUSTRY, 501 ST. PAUL PLACE, BALTIMORE, MARYLAND 21202 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 _____

<i>Week No.</i>	<i>Month</i>	<i>Week Ending Day</i>	<i>Year</i>	<i>GROSS Days Worked</i>	<i>Amount Paid Including all Overtime</i>
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 _____