

# WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

<b>G E N E R A L</b>	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 #							
<b>C L A I M S  A D M I N</b>	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															
<b>E M P L O Y E E</b>	NAME (LAST, FIRST, MIDDLE)				DATE OF BIRTH		SOCIAL SECURITY NUMBER		DATE HIRED		STATE OF HIRE					
	ADDRESS (INCL ZIP)				SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN		MARITAL STATUS UNMARRIED SINGLE/DIVORCED MARRIED SEPARATED UNKNOWN		OCCUPATION/JOB TITLE							
	TELEPHONE (INCLUDE AREA CODE)				# OF DEPENDENTS				EMPLOYMENT STATUS							
									NCCI CLASS CODE							
<b>W A G E</b>	RATE		PER:		DAY		MONTH		# DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY?		YES		NO	
			WEEK		OTHER:						DID SALARY CONTINUE?		YES		NO	
<b>O C C U R R E N C E</b>	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 <input type="checkbox"/> YES <input type="checkbox"/> 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? WERE THEY USED?				YES		NO	
<b>T R E A T M E N T</b>	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							
<b>O T H E R</b>	WITNESS (NAME & PHONE #)												4 HOSPITALIZED > 24HRS			
													5 FUTURE MAJOR MEDICAL/ LOSS 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 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

<i>Week No.</i>	<i>Month</i>	<i>Week Ending Day</i>	<i>Year</i>	<i>Days Worked</i>	<i>Gross</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 \_\_\_\_\_