INSTRUCTIONS

COMPLETING EMPLOYEE FIRST REPORT OF INJURY

1. Employee or an individual acting on the employee's behalf completes the Employee First Report of Injury Form.

2. Supervisor or another responsible administrative official completes the Supervisor's Report of Injury and Concentra Form.

3. **INJURED EMPLOYEES SHOULD BE SEEN ON A WALK-IN BASIS WITHIN 3 WORKING DAYS OF THE ACCIDENT IN ANY OF NINE CONCENTRA MEDICAL CENTERS THROUGHOUT THE STATE. THE EMPLOYEE MAY CARRY OR THE PERSONNEL OFFICE MAY FAX THE REFERRAL FORM TO THE MEDICAL CENTER**.

NOTE:

THE COMPLETED FIRST REPORT OF INJURY PACKET SHOULD BE GIVEN TO RON NULL IN THE OFFICE OF HUMAN RESOURCES WITHIN 3 WORKING DAYS AFTER THE INJURY OCCURS. THE INFORMATION MAY BE EMAILED TO RON AT RON.NULL@MARYLAND.GOV OR BROUGHT DOWN TO RON IN ROOM 106A. FAILURE TO PROVIDE THE PROPER DOCUMENTATION WITHIN THE ESTABLISHED TIME FRAME COULD RESULT IN A DELAY OR DISAPPROVAL OF ACCIDENT LEAVE. FOR ANY ADDITIONAL QUESTIONS, PLEASE CONTACT RON NULL AT 410-767-6387.

Employee's Report of Injury

(To be completed by the employee only.)

Employee's name: _____ Male__Female__
Last First Middle

Date of birth: __ / __ / __ Home telephone # (_____) _____

Home address: _____ _

City: _____ State: _____ Zip Code: _____

Present classification: _____ How long employed here: _____

Social Security No.: _____ - _____- _____ Weekly salary:

Location of accident: _____
Address Area (loading dock, bathroom, etc.)

Date of accident: _____ Time of accident: _____

Describe fully how accident occurred: (including events that occurred immediately before the accident):

Describe bodily injury sustained (be specific about body part(s) affected):

Recommendation on how to prevent this accident from recurring: _____

Name of supervisor: _____ _____ _____ Phone# _____
Last First

Name(s) of witness(es): _____ Phone# _____
(Attach witness(es) report(s))

When did you report the accident to your supervisor? _____

To whom did you report the injury? _____

Do you require medical attention? Yes: _____ No: _____ Maybe: _____ _

Name of your treating physician: _____ Phone# _____

Signature of employee: _____ Date: _____

Accident Witness Statement

(To be completed by accident witness)

Injured employee's name: _____
Last First Middle

Name of witness: _____ Ph# _____
Last First Middle

Job title of witness: _____ How long employed here? _____

Home address of witness: _____

City: _____ State: _____ Zip Code: _____

Location of accident: _____ _____
Address/Name of building Area (bathroom, etc.)

Date of accident: _____ Time of accident: _____

Describe fully how accident occurred: (including events that occurred immediately before the accident):

_____

_____

_____

_____

_____

Describe bodily injury sustained (be specific about body part(s) affected):

_____

_____

_____

_____

_____

Recommendation on how to prevent this accident from recurring: _____

Name of Witness's Supervisor: _____ Ph# _____
Last First

Signature of Witness: _____ Date: _____

204B 01/03

Supervisor's Accident Investigation

(To be completed by the employee's supervisor or other responsible administrative official)

Location where accident occurred		Employer's Premises: ☐ Yes ☐ No Job site: ☐ Yes ☐ No	Date of accident or illness
Who was injured?		☐ Employee ☐ Non-Employee	Time of accident a.m. or p.m.
Length of time with firm	Job title or occupation	Name of dept. normally assigned to	How long has employee worked at job where injury or illness occurred? Property/equipment owned by:
What property/equipment was damaged?			
What was employee doing when injury/illness occurred? What machine or tool was being used? What type of operation?			
How did injury/illness occur? List all objects and substances involved.			
Part of body affected/injured?		Any prior physical conditions? If so, what? ☐ Yes ☐ No	
Nature and extent of injury/illness and property damaged (be specific)			

PLEASE INDICATE ALL OF THE FOLLOWING WHICH CONTRIBUTED TO THE INJURY OR ILLNESS

__ Failure to lockout	__ Failure to secure	__ Horseplay
__ Improper dress	__ Improper guarding	__ Improper instruction
__ Improper maintenance	__ Improper protective equipment	__ Inoperative safety device
__ Lack of training or skill	__ Operating without authority	__ Physical or mental impairment
__ Poor housekeeping	__ Poor ventilation	__ Unsafe arrangement or process
__ Unsafe equipment	__ Unsafe position	__ Other _____

Supervisor's corrective action to ensure this type of accident does not recur: _____

_____

_____

Was employee trained in the appropriate use of Personal Protective Equipment/Proper safety procedures? _____ Yes _ No __

Was employee cautioned for failure to use Personal Protective Equipment/Proper safety procedures? _____ Yes _ No __

Did employee promptly report the injury/illness? _____ Yes _ No __

Is there modified duty available? _____ Yes _ No __

_____

Supervisor's name Supervisor's signature Phone# Date

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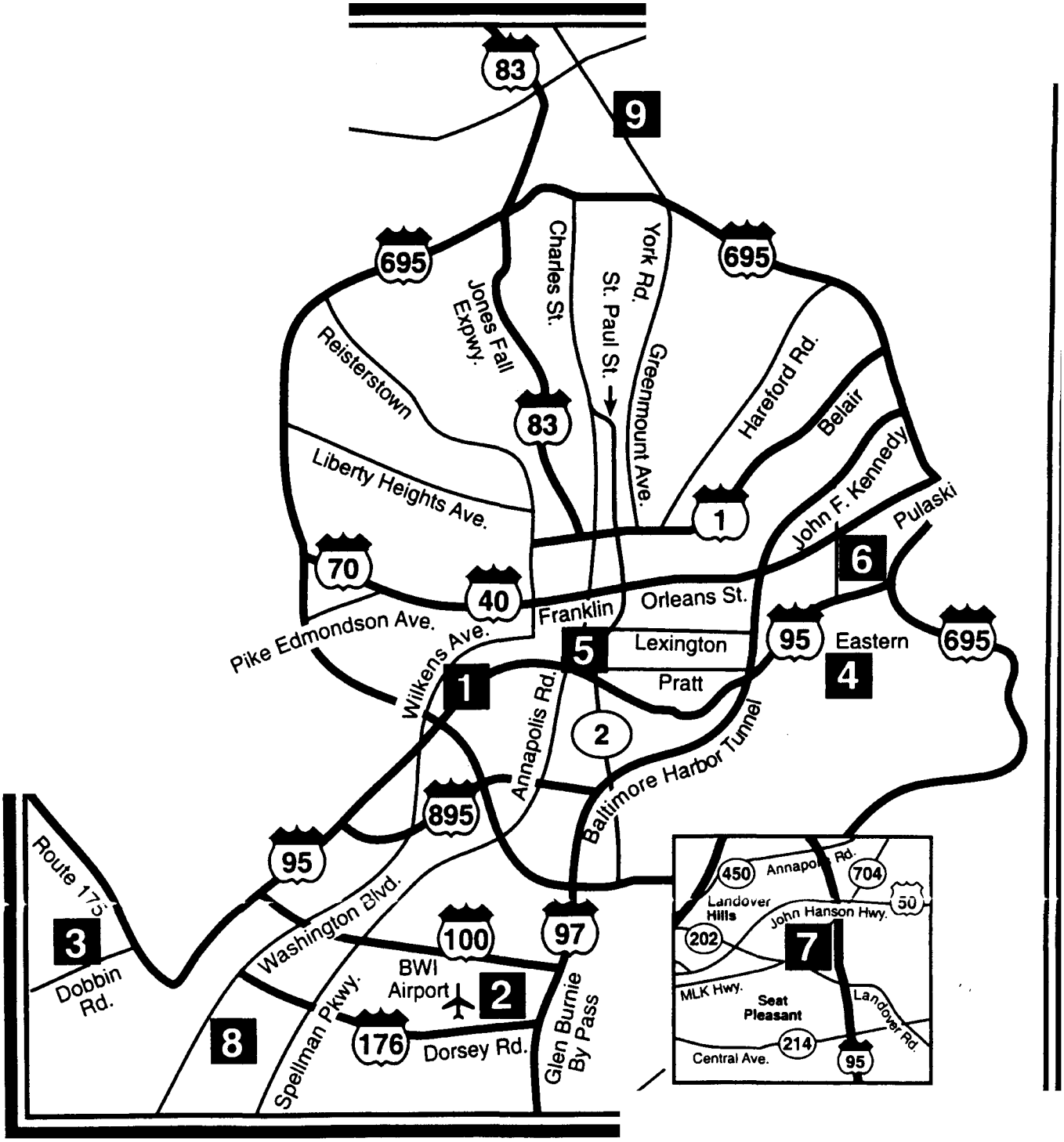
Form may be copied as needed

MARYLAND LOCATIONS

CONCENTRA

MEDICAL CENTERS

THE OCCUPATIONAL HEALTH CARE SOLUTION



MARYLAND LOCATIONS

CONCENTRA

MEDICAL CENTERS

THE OCCUPATIONAL HEAITHCARE SOLUTION

1 Arbutus

AFTER HOURS FACILITY
1419 Knecht Avenue
Baltimore, MD 21227

410-247-9595

FAX: 410-247-7553
Hours: 7:00 a.m. Monday -
12:00 noon Saturday
(24 Hours)

2 BWl

890 Airport Park Road
Suite 100
Glen Burnie, MD 21061

410-553-0110

FAX: 410-553-0197
Hours: 7:30 a.m. - 5:00 p.m.
Monday - Friday

3 Columbia

6656 Dobbin Road
Columbia, MD 21045
410-381-1330

FAX: 410-381-5585

Hours: 8:00 a.m. - 5:00 p.m.
Monday - Friday

4 Dundalk

Holabird Industrial Park
1833 Portal St.
Baltimore, MD 21224
410-633-3600
FAX: 410-633-3604
Hours: 8 a.m. - 5:00 p.m.
Monday - Friday

5 Inner Harbor

100 South Charles St., Suite 150
Baltimore, MD 21201
410-752-3010
FAX: 410-539-7023
Hours: 8:00 a.m. - 5:00 p.m.
Monday - Friday

6 Rosedale

8101 Pulaski Hwy., Suite H. I, J
Baltimore, MD 21237
410-687-6462
FAX: 410-687-2261
Hours: 7:00 a.m. – 7 p.m.
Monday - Friday
7:00 a.m. - 12:00 noon
Saturday

7 Lanham

4451 G Parliament Place
Lanham, MD 20706
301-459-9113
FAX: 301-459-1214
Hours: 7:00 a.m. – 8:00 p.m.
Monday - Friday
7:00 a.m. - 12:00 noon
Saturday

8 Jessup

7377 Washington Blvd., Ste. 101-102
Elkridge, MD 21075
410-379-3051
FAX: 410-379-3074
Hours: 8 a.m. - 5:00 p.m.
Monday - Friday

9 Timonium

1840 York Road, Ste. E.
Timonium, MD 21093
410-252-4015
FAX: 410-252-7410
Hours: 8 a.m. - 5:00 p.m.
Monday - Friday

Center Information

- All patients are seen on a walk-in basis. Work-related injuries receive immediate triage assessment.
- Pre-placement exams and DOT physicals are seen on a walk-in basis. Exam forms are provided, or you may use your company's specific forms.
- Working with CMC requires no contract. Our fees are competitive and adhere to the applicable state workers' compensation fee guidelines.

After Hours Emergency Network Provider

Report to:
Mercy Hospital Emergency Department 301 Saint Paul Pl.
Baltimore, MD 21202 410-332-9477

REQUEST FOR SERVICES

INJURY CARE

Employee's Name _____Social Security # _____

Date of Request _____ Date of Birth _____

Home Phone # _____ Work Phone # _____

Address _____

Occupation/Job Title _____

Scheduled Date of Exam _____Time _____Network Site _____

Authorized by _____ Agency Phone # _____

Agency _____ Agency Fax # _____

SERVICE REQUESTED:

__ Injury care Date of Incident: _____ Injury: _____

__ Injury Evaluation/Second Opinion/Periodic Injury Evaluation (P.I.E.)

The following should be forwarded to the center or accompany the patient to the center at time of appointment:

A. Employee's position description/job description
B. Must call in First Report of Injury for Work Injury/Illness to Injured Workers' Insurance Fund

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********** (Employee Section) **********

This will authorize the State Medical Director's Office to release all pertinent information with regard to the diagnosis, evaluation, treatment, and prognosis of the condition being evaluated to my employer, the insurance carrier or the agents. This also authorizes The State Medical Director's Office to obtain all pertinent information with regard to the diagnosis, evaluation, treatment, and prognosis of the condition being evaluated and/or treated.

Employee's Signature _____ Date _____

(OVER)

Provider Section

Diagnosis _____ Health Classification with respect to physical/mental requirements of the job:

l. _____ Recommended/regular activities

2. _____ Recommended pending ancillary testing

Health-related condition(s) exists which may interfere with performance of essential job functions:

Current Activity Status:

Lifting Limits (weight range and frequency) _____
Sitting (needs and limits) _____
Mobility Impairment (specify) _____
Vision/Hearing Impairment (specify) _____
Mental Health Needs _____
Travel (specify needs and limits) _____
Working Hours _____

4. _____Deferred/pending - further evaluation by _____

5. _____Does not meet US DOT requirements/essential job functions

6. _____Other/ Comments

The above activity restrictions expire: _____

The above health classification was explained to patient: __ yes ___no

Employee's Signature _____ Date _____

Examining Professional (print) _____

Examining Professional's Signature _____ Date _____

This assessment was performed _ with __ without a written statement describing the essential functions of the job.

A copy of this form completed by the provider should be placed in a sealed envelope and returned to the designated agency contact.

Time In w/Initials _____ Time Out w/Initials _____