

# WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

<b>EMPLOYER (NAME &amp; ADDRESS INCL ZIP)</b> Name: _____ Address: _____ City: _____ State: <b>MD</b> Zip: _____ INDUSTRY CODE: _____ EMPLOYER FEIN: _____		<b>CARRIER/ADMINISTRATOR CLAIM</b> OSHA LOG: _____ REPORT PURPOSE: _____ JURISDICTION: _____ JURISDICTION CLAIM NUMBER: _____ INSURED REPORT NUMBER: _____	
<b>CARRIER (NAME, ADDRESS, &amp; PHONE #)</b> Name: _____ Address: _____ City: _____ State: <b>MD</b> Zip: _____ Phone: ( ) - _____ CARRIER FEIN: _____ POLICY/SELF-INSURED NUMBER: _____		<b>POLICY PERIOD</b> TO: // FROM: // CHECK IF APPROPRIATE <input type="checkbox"/> SELF INSURANCE	
<b>EMPLOYEE</b> Last Name: _____ Middle: _____ First Name: _____ Address: _____ City: _____ State: <b>MD</b> Zip: _____ Phone: ( ) - _____ # OF DEPENDENTS: _____		<b>CLAIMS ADMINISTRATOR (NAME, ADDRESS &amp; PHONE NO)</b> Name: _____ Address: _____ City: _____ State: <b>MD</b> Zip: _____ Phone: ( ) - _____ ADMINISTRATOR FEIN: _____	
<b>WAGE</b> RATE: _____ PER: <input type="radio"/> Day <input type="radio"/> Week <input type="radio"/> Month <input type="radio"/> Other # DAYS WORKED/WEEK: <b>5</b>		FULL PAY FOR DAY OF INJURY? <input type="radio"/> Yes <input type="radio"/> No DID SALARY CONTINUE? <input type="radio"/> Yes <input type="radio"/> No	
TIME EMPLOYEE BEGAN: _____ DATE OF INJURY/ILLNESS: // TIME OF OCCURRENCE: _____ LAST WORK DATE: // DATE EMPLOYER NOTIFIED: // DATE DISABILITY BEGAN: //		SOCIAL SECURITY: - - DATE HIRED: // STATE OF HIRE: <b>MD</b> SEX: <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Unknown MARITAL STATUS: <input type="radio"/> Unmarried Single/Divorced <input type="radio"/> Married <input type="radio"/> Separated <input type="radio"/> Unknown OCCUPATION/JOB TITLE: _____ EMPLOYMENT STATUS: <b>Full-Time</b> NCCI CLASS CODE: _____	
<b>CONTACT NAME</b> : _____ <b>CONTACT PHONE</b> : ( ) - _____ <b>TYPE OF INJURY/ILLNESS</b> : _____ <b>PART OF BODY AFFECTED</b> : _____			
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="radio"/> Yes <input type="radio"/> No		<b>TYPE OF INJURY/ILLNESS CODE</b> : _____ <b>PART OF BODY AFFECTED CODE</b> : _____	
<b>DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE</b> : _____		<b>ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED</b> : _____	
<b>SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED</b> : _____		<b>WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED</b> : _____	
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			<b>CAUSE OF INJURY CODE</b> : _____
DATE RETURN(ED) TO WORK: //		IF FATAL, GIVE DATE OF DEATH: //	
		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? <input type="radio"/> Yes <input type="radio"/> No WERE THEY USED? <input type="radio"/> Yes <input type="radio"/> No	
<b>PHYSICIAN/HEALTH CARE PROVIDER (NAME &amp; ADDRESS)</b> Name: _____ Address: _____ City: _____ State: <b>MD</b>		<b>HOSPITAL OR OFF SITE TREATMENT (NAME &amp; ADDRESS)</b> Name: _____ Address: _____ City: _____ State: <b>MD</b>	
<b>WITNESS NAME</b> : _____ <b>ADMINISTRATOR NOTIFIED</b> : // <b>PREPARER'S EMAIL ID</b> : _____		<b>INITIAL TREATMENT</b> <input type="checkbox"/> NO MEDICAL TREATMENT <input type="checkbox"/> MINOR BY EMPLOYER <input type="checkbox"/> MINOR CLINIC/HOSP <input type="checkbox"/> EMERGENCY CARE <input type="checkbox"/> HOSPITALIZED > 24 HOURS <input type="checkbox"/> FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED PHONE NUMBER: ( ) - _____	
DATE PREPARED: <b>05/24/2005</b> PREPARER'S NAME & TITLE: _____		PHONE NUMBER: ( ) - _____	