WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)
Name
Address
City State MD
Zip -
INDUSTRY CODE
EMPLOYER FEIN

CARRIER/ADMINISTRATOR CLAIM | OSHA LOG | REPORT PURPOSE
JURISDICTION | JURISDICTION CLAIM NUMBER
INSURED REPORT NUMBER
EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | LOCATION # ( ) -
Address
City State MD Zip - | PHONE # ( ) -

CARRIER (NAME, ADDRESS, & PHONE #)
Name
Address
City State MD
Zip - Phone ( ) -
CARRIER FEIN
POLICY/SELF-INSURED NUMBER

POLICY PERIOD / /
TO / /
CHECK IF APPROPRIATE
☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
Name
Address
City State MD
Zip - Phone ( ) -
ADMINISTRATOR FEIN

EMPLOYEE Last Name | Middle
First Name
Address
City State MD
Zip - Phone ( ) -
OF DEPENDENTS

DATE OF BIRTH / /
SOCIAL SECURITY - -
DATE HIRED / /
STATE OF HIRE MD
SEX
○ Male ○ Female ○ Unknown
MARITAL STATUS
○ Unmarried Single/Divorced ○ Married ○ Separated ○ Unknown
OCCUPATION/JOB TITLE
EMPLOYMENT STATUS Full-Time
NCCI CLASS CODE

WAGE RATE PER: ○ Day ○ Week ○ Month ○ Other
DAYS WORKED/WEEK 5
FULL PAY FOR DAY OF INJURY? ○ Yes ○ No
DID SALARY CONTINUE? ○ Yes ○ No

TIME EMPLOYEE BEGAN : ○ AM ○ PM
DATE OF INJURY/ILLNESS / /
TIME OF OCCURRENCE : ○ AM ○ PM ○ Unknown
LAST WORK DATE / /
DATE EMPLOYER NOTIFIED / /
DATE DISABILITY BEGAN / /

CONTACT NAME | CONTACT PHONE ( ) - | 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
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

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)
Name
Address
City State MD -

HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)
Name
Address
City State MD -

INITIAL TREATMENT
○ NO MEDICAL TREATMENT
○ MINOR BY EMPLOYER
○ MINOR CLINIC/HOSP
○ EMERGENCY CARE
○ HOSPITALIZED > 24 HOURS
○ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

WITNESS NAME | PHONE ( ) -

ADMINISTRATOR NOTIFIED / / | DATE PREPARED | PREPARER'S NAME & TITLE | PHONE NUMBER ( ) -
PREPARER'S EMAIL ID:

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