

WORKER'S COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

OSHA CASE/FILE#

G E N E R A L	EMPLOYER (NAME & ADDRESS INCL ZIP)				CARRIER/ADMINISTRATOR CLAIM NUMBER											
	Prince George's County Government 1301 McCormick Drive Upper Marlboro, Maryland 20774				JURISDICTION		JURISDICTION CLAIM NUMBER									
	SIC CODE N/A				UNEMPLOY FED TAX I.D. NO.: 52-6000998		LOCATION # PHONE #									
C L A I M S C A R R I E R A D M I N	CARRIER (NAME, ADDRESS & PHONE NO)				POLICY PERIOD		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)									
					CHECK IF APPROPRIATE		Prince George's County Fire/EMS Dept. Health & Wellness Office 6820 Webster Street, Rm 120 Landover Hills, MD 20784									
					X SELF INSURANCE											
	CARRIER FIEN		POLICY/SELF-INSURED NUMBER S-1810		ADMINISTRATOR FEIN											
AGENT NAME & CODE NUMBER																
NAME (LAST, FIRST, MIDDLE)				DATE OF BIRTH		SOCIAL SECURITY NUMBER		DATE HIRED		STATE OF HIRE						
ADDRESS (INCL ZIP)				SEX		MARITAL STATUS		OCCUPATION/JOB TITLE								
				MALE		UNMARRIED SINGLE/DIVORCED		EMPLOYMENT STATUS								
				FEMALE		MARRIED										
				UNKNOWN		SEPARATED										
TELEPHONE (INCLUDE AREA CODE)				# OF DEPENDENTS		UNKNOWN		NCCI CLASS CODE								
W A G E	RATE		X		HOUR		MONTH		# DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY?		YES		NO	
	PER:		Week		OTHER: AVERAGE WAGE/WEEK AT TIME OF INJURY \$						DID SALARY CONTINUE?		YES		NO	
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		DATE EMPLOYER NOTIFIED		INDIVIDUAL NOTIFIED	
			PM						PM							
	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							
	YES				NO											
	PLACE OF ACCIDENT OR OCCURRENCE (Incl. State)															
	DESCRIBE NATURE OF INJURY OR ILLNESS IN DETAIL (Include part of body affected, eg., amputation of right index finger at 2 nd joint, fractured arm, lead poisoning) DESCRIBE EMPLOYEE'S ACTIVITIES WHEN INJURY OCCURRED WITH DETAILS OF HOW EVENT OCCURRED (include name of other individuals involved, tools, machinery, objects, vapors, chemicals, radiations, unnatural motions of employee)															
DATE RETURN(ED) TO WORK				IF FATAL, GIVE DATE OF DEATH				WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?				YES		NO		
								WERE THEY USED?				YES		NO		
T R E A T M E N T	PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)				HOSPITAL (NAME & ADDRESS)				INITIAL TREATMENT (CHECK ONE)							
									<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 HRS <input type="checkbox"/> FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED							
O T H E R	WITNESS TO INJURY (NAME & PHONE #)															
	DATE MAILED TO INSURER			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, 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 form 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

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