# WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

| EMPLOYER | EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) |
|---|---|
| Charles County Commissioners<br>200 Baltimore Street<br>La Plata, Maryland 20646 | |
| **CARRIER/ADMINISTRATOR CLAIM NUMBER** | **POLICY/SELF-INSURED NUMBER** |
| | **Self Insured** |

| EMPLOYEE NAME (LAST, FIRST, MIDDLE) | SEX | MARITAL STATUS | OCCUPATION/JOB TITLE |
|---|---|---|---|
| | MALE ☐ | SINGLE/DIVORCED ☐ | |
| | FEMALE ☐ | MARRIED ☐ | |
| **ADDRESS (INCL. ZIP)** | | SEPARATED ☐ | **DATE HIRED** |
| | | UNKNOWN ☐ | |
| | **DT OF BIRTH** | **SOCIAL SECURITY #** | **TELEPHONE NUMBER** |
| | | | |

| WAGE RATE | PER HR | # DAYS WORKED/WEEK | |
|---|---|---|---|

| TIME WORK BEGAN | DATE OF INJURY/ILLNESS | TIME OF OCCURRENCE | LAST WORK DATE |
|---|---|---|---|
| | | | |
| **DATE EMPLOYER NOTIFIED** | **DATE DISABILITY BEGAN** | **CONTACT NAME AND TELEPHONE NUMBER** | |
| | | | |
| **TYPE OF INJURY/ILLNESS** | | **PART OF BODY AFFECTED** | |
| **OCCURRED ON EMPLOYER'S PREMISES?** | | **DEPARTMENT OR LOCATION WHERE OCCURRED** | |
| **YES** ☐ **NO** ☐ | | | |

**SPECIFY ACTIVITY EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT/ILLNESS EXPOSURE OCCURED**

**DESCRIBE SEQUENCE OF EVENTS & INCLUDE ANY OBJECTS/SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL**

| DATE RETURN(ED) TO WORK | | IF FATAL, GIVE DATE OF DEATH | |
|---|---|---|---|

**WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? USED?** **YES** ☐ **NO** ☐

| PHYSICAN/HEALTH CARE PROVIDER (NAME & ADDRESS) | HOSPITAL (NAME & ADDRESS) |
|---|---|
| | |

| INITIAL TREATMENT | NO MEDICALTREATMENT | MINOR: BY EMPLOYER | MINOR CLINIC/HOSP | EMERGENCY CARE | HOSPITAL 24 HOURS | FUTURE MAJ MED LOST TIME ANTIC |
|---|---|---|---|---|---|---|
| | | | | | | |

| WITNESS (NAME & PHONE #) | |
|---|---|
| **PREPARER'S NAME, TITLE & PHONE NUMBER** | |
| **DATE PREPARED** | **DATE ADMINISTRATOR NOTIFIED** |