APPENDIX GG – RESPONDER INJURY REPORTING PACKET

During MDRMRC authorized activities, volunteers are considered to be State employees and therefore have workers' compensation benefits. Injuries sustained during a MDRMRC authorized activity must be documented and submitted using the forms and instructions in the packet below.

MARYLAND RESPONDS

INJURY REPORT PACKET

During Maryland Responds Medical Reserve Corps authorized activities, volunteers are considered to be State employees and therefore have workers' compensation benefits. Injuries sustained during a Maryland Responds Medical Reserve Corps authorized activity must be documented using the forms contained in this packet. All completed forms must be submitted to the Maryland Responds MRC Program Office via email (Karen.Hopper1@maryland.gov).

INSTRUCTIONS:

1. Inform a Maryland Responds State Administrator of your injury by using the contact information below.

Karen Hopper	Mallory Simcox
Cell Phone: 443-934-5849	Cell Phone: 443-257-5588
Email: karen.hopper1@maryland.gov	Email: mallory.simcox@maryland.gov

2. The injury should be documented using the following forms:

   - Injured volunteer completes the Employee's Report of Injury Form (page 2). If you are physically unable to fill out the Employee's Report of Injury Form, you can fill it out at a later time, or have someone fill it out on your behalf.
   - A Maryland Responds State Administrator or other responsible administrative official completes the Supervisor's Accident Investigation Form (page 3) and the Authorization for Examination or Treatment Form (page 5).
   - Any witness to the accident completes the Accident Witness Statement (page 4).
     Submit completed forms to the Maryland Responds MRC Program Office via email (mdresponds.health@ maryland.gov) or via fax (410-333-5000) within three (3) days of the incident.
     A State Administrator will forward the forms to the appropriate authority.
   - Make and keep copies of these forms for your files. These completed forms can provide valuable information in a claims investigation of an injury and for developing the defense in the event of a workers' compensation hearing.

3. If you require treatment from a health care professional, you can be seen on a walk-in basis at any of the WorkPro Occupational Health or Occupational Medical Services (OMS) locations. It is recommended that this be done within three (3) days of the incident. For locations and office hours, see pages 6 and 7.

   - Contact the Maryland Responds MRC Program Office/State Administrators to notify them of which WorkPro location you will be visiting for treatment. This is necessary so that we may fax the Authorization for Examination or Treatment Form (page 5) to them prior to your visit.

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: _____

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

IWIF • 8722 Loch Raven Boulevard, Towson, MD 21286-2235 • www.iwif.com

Form may be copied as needed

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

WORKPRO OCCUPATIONAL HEALTH

OMS OCCUPATIONAL MEDICAL SERVICES Your Partner in Employee Health

State of Maryland

Authorization for Examination or Treatment

(Patient Must Present Photo ID at Time of Service)

Agency:_____ **Today's Date:**_____

(List Agency or Sub-Agency to Receive Invoice) **Appointment Date/Time** (if any): _____

Location:_____ **Authorized By:** _____

Agency Phone No.:_____ **Agency Fax No:** _____

Employee:_____ **Employee Date of Birth:**_____

Please check all that apply:

☑ **Work Injury/Illness** Date of Injury_____ Claim# (if available) _____

Physical Examination

☐ Pre-placement ☐ Pre-placement w Ergonomic Assessment ☐ DOT - Regulated

☐ Fitness for Duty/Ability to Work ☐ Medical Surveillance ☐ FAA - MDOT

☐ Other: _____

Substance Abuse Testing

☐ DOT - Regulated Drug Test ☐ MDOT Non-regulated Drug Test

☐ DOT – Regulated Alcohol (Breath) ☐ MDOT Non-regulated Alcohol Test (Saliva)

☐ Other: _____

Reason for Substance Abuse Testing

☐ Pre-employment ☐ Reasonable Suspicion ☐ Post-accident ☐ Random

☐ Follow-up ☐ Return to Duty

Psychological Services (scheduled through WORKPRO Elkridge MD location)

☐ Psychological Testing ☐ SAP ☐ Critical Incident Management

Other Services

☐ Respirator Fit Test ☐ Audiogram ☐ PPD ☐ Pulmonary Function Test ☐ EKG

☐ Chest X-ray ☐ Vaccination:_____ ☐ Other:_____

Special instructions/comments _____

_____

_____

For WORKPRO locations and individual office hours visit www.workprohealth.com

WORKPRO Occupational Health Locations
&
Occupational Medical Services (OMS) Locations
Effective 4/1/17

Note: Contact Names, Numbers, Emails to follow.

WORKPRO Maryland

6785 Business Parkway, Suites 1&2
Elkridge, MD 21075
Hours: Mon – Fri 7:30am – 4:30pm

844 Washington Road, Unit 203
Westminster, MD 21157
Hours: Mon – Fri 7:30am – 4:30pm

2618 North Salisbury Blvd, Suite 130
Salisbury, MD 21801
Hours: Mon – Fri 7:30am – 4:30pm

Opening Date: 4/1/17

2875 Crain Highway
Route 301 South
Waldorf, MD 20601
Hours: Mon – Fri 7:30am – 4:30pm

14302 Barton Boulevard SW
Cumberland, MD 21502
Hours: Mon – Fri 7:30am – 4:30pm

WORKPRO Delaware

914 Justison Street
Shipyard Shops
Wilmington, DE 19801
Hours: Mon - Fri 7:30am – 5:00pm

4051 Ogletown-Stanton Road, Suite 102
Iron Hill Corporate Center, Sabre Wing
Newark, DE 19713
Hours: Mon - Fri 7:30am – 5:00pm

283 North DuPont Highway
Kohl's Center
Dover, DE 19901
Hours: Mon – Fri 7:30am – 4:30pm

543 North Shipley Street
Professional Building, Suite F
Seaford, DE 19973
Hours: Mon - Fri 7:30am – 4:30pm

503 W. Market Street, Suite 100
Nanticoke Immediate Care
Georgetown, DE 19947
Hours: Mon - Fri 7:30am – 4:30pm

OMS Locations

Arbutus
4807 Benson Avenue
Baltimore, MD 21227
Hours: Open 24 Hrs

Belcamp
1200 Brass Mill Road, Suite C
Belcamp, MD 21017
Hours: Mon – Fri 7:00am – 5:00pm

Canton
3600 O'Donnell Street, Suite 170
Baltimore, MD 21224
Hours: Mon – Fri 7:30am – 5:00pm

Greenbelt:
7933 Belle Point Drive,
Greenbelt, MD 20770
Hours: Mon – Fri 8:00am – 4:30pm

State of Maryland - WORKPRO & OMS

WORKPRO DE Sites

- WORKPRO, Wilmington DE
- WORKPRO, Newark DE
- WORKPRO, Dover DE
- WORKPRO, Georgetown DE
- WORKPRO Seaford DE

WORKPRO Maryland

- WORKPRO/Pivot, Westminster
- WORKPRO Salisbury
- 6785 Business Pkwy - Elkridge
- WORKPRO Cumberland
- WORKPRO, Waldorf

Occupational Medical Services

- OMS, B'More (Arbutus)
- OMS, B'More (Canton)
- OMS, Belcamp
- OMS, Greenbelt