INJURY REPORT PACKET

Injuries sustained during an MD Responds MRC authorized activity must be documented using the forms contained in this packet. Submit all completed forms to MD Responds MRC Program Office via email (mdresponds.dhmh@maryland.gov) or via fax (410-333-5000).

INSTRUCTIONS:

1. Document the injury 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, more appropriate time, or have someone fill it out on your behalf.

   - Supervisor or another responsible administrative official completes the **Supervisor's Accident Investigation Form** (page 3).

   - Any witness to the accident completes the **Accident Witness Statement** (page 4).

2. Submit all completed forms to MD Responds MRC Program Office via email (mdresponds.dhmh@maryland.gov) or via fax (410-333-5000), who will forward the forms to the State Claims Adjuster.

   - Also, 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' comp hearing.

3. If you require treatment from a health care professional, you must be seen on a walk-in basis within 3 working days of the incident in any of the nine Concentra Medical Centers throughout the state. For locations, see the **Concentra Medical Center Map** on page 5.

   - Contact the MD Responds Program Office to notify them of which Concentra Medical Center you will be visiting for treatment. This is necessary so that we may fax them a **Referral Form** (page 7) prior to your visit.

MD Responds Medical Reserve Corps
Maryland Department of Health & Mental Hygiene, Office of Preparedness & Response
300 W. Preston Street, Suite 202, Baltimore, MD 21201
Email: mdresponds.dhmh@maryland.gov; Fax: 410-333-5000

or MD Responds MRC Volunteer's

Chesapeake Employers Insurance
Your workers' compensation specialist

Employee's Report of Injury

Policyholder: _____

Policy #: _____

(To be completed by the employee only.)

Employee's name: _____ Male__ Female__
Last First Middle

Date of birth: ____/____/____ Home telephone # (_____) _____

Marital status: M / D / W / S Height/Weight: _____" /_____ lbs. __Right- or __left-hand dominant

Home address: _____

City: _____ State: _____ Zip Code: _____

Current job position: _____ How long employed here: _____

Social Security No.: _____-_____-_____ Weekly salary: _____

Location of accident:_____
Address and location of accident (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: _____

Chesapeake Employers Insurance
Your workers' compensation specialist

Supervisor's Accident Investigation Form

Policyholder: _____

Policy #: _____

(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 ☐ If non-employee, specify_____	Time of accident a.m. ☐ 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?
What property/equipment was damaged?			Property/equipment owned by:
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.			
Was the accident the result of another party's negligence? If so, name of the negligent party:			
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):			
Do you have any concerns about this alleged accident or injury? If so, please specify:			

PLEASE INDICATE ALL OF THE FOLLOWING WHICH CONTRIBUTED TO THE INJURY OR ILLNESS

____ Failure to lockout	____ Improper maintenance	____ Poor housekeeping
____ Failure to secure	____ Improper protective equipment	____ Poor ventilation
____ Horseplay	____ Inoperative safety device	____ Unsafe arrangement or process
____ Improper dress	____ Lack of training or skill	____ Unsafe equipment
____ Improper guarding	____ Operating without authority	____ Unsafe position
____ Improper instruction	____ Physical or mental impairment	____ 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 using the appropriate Personal Protective Equipment/proper safety procedures at the time?....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

Chesapeake Employers Insurance
Your workers' compensation specialist

Accident Witness Statement

Policyholder: _____

Policy #: _____

(To be completed by accident witness.)

Injured employee's name: _____
Last First Middle

Name of witness: _____ Phone # _____
Last First Middle

Job title of witness: _____ How long employed here? _____

Home address of witness: _____

City: _____ State: _____ Zip Code: _____

Is witness any relation to the injured employee? ___Yes ___No If yes, what relation? _____

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' supervisor: _____ Ph # _____
Last First

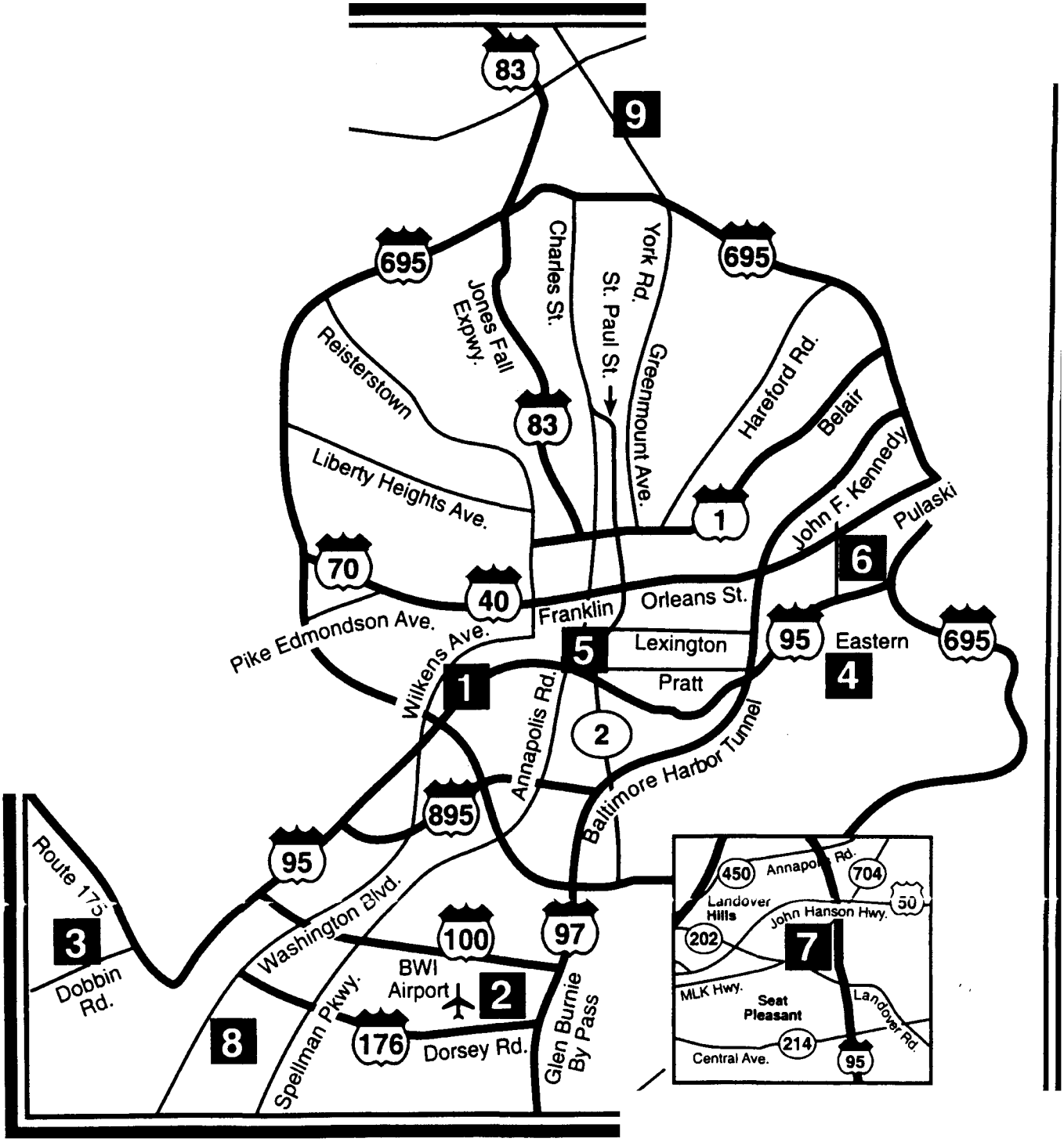
Signature of witness: _____ Date: _____

MARYLAND LOCATIONS

CONCENTRA

MEDICAL CENTERS

THE OCCUPATIONAL HEALTH CARE SOLUTION



MARYLAND LOCATIONS

CONCENTRA

MEDICAL CENTERS

THE OCCUPATIONAL HEAITHCARE SOLUTION

1 Arbutus

AFTER HOURS FACILITY
1419 Knecht Avenue
Baltimore, MD 21227

410-247-9595

FAX: 410-247-7553
Hours: 7:00 a.m. Monday -
12:00 noon Saturday
(24 Hours)

2 BWl

890 Airport Park Road
Suite 100
Glen Burnie, MD 21061

410-553-0110

FAX: 410-553-0197
Hours: 7:30 a.m. - 5:00 p.m.
Monday - Friday

3 Columbia

6656 Dobbin Road
Columbia, MD 21045
410-381-1330

FAX: 410-381-5585

Hours: 8:00 a.m. - 5:00 p.m.
Monday - Friday

4 Dundalk

Holabird Industrial Park
1833 Portal St.
Baltimore, MD 21224
410-633-3600
FAX: 410-633-3604
Hours: 8 a.m. - 5:00 p.m.
Monday - Friday

5 Inner Harbor

100 South Charles St., Suite 150
Baltimore, MD 21201
410-752-3010
FAX: 410-539-7023
Hours: 8:00 a.m. - 5:00 p.m.
Monday - Friday

6 Rosedale

8101 Pulaski Hwy., Suite H. I, J
Baltimore, MD 21237
410-687-6462
FAX: 410-687-2261
Hours: 7:00 a.m. – 7 p.m.
Monday - Friday
7:00 a.m. - 12:00 noon
Saturday

7 Lanham

4451 G Parliament Place
Lanham, MD 20706
301-459-9113
FAX: 301-459-1214
Hours: 7:00 a.m. – 8:00 p.m.
Monday - Friday
7:00 a.m. - 12:00 noon
Saturday

8 Jessup

7377 Washington Blvd., Ste. 101-102
Elkridge, MD 21075
410-379-3051
FAX: 410-379-3074
Hours: 8 a.m. - 5:00 p.m.
Monday - Friday

9 Timonium

1840 York Road, Ste. E.
Timonium, MD 21093
410-252-4015
FAX: 410-252-7410
Hours: 8 a.m. - 5:00 p.m.
Monday - Friday

Center Information

- All patients are seen on a walk-in basis. Work-related injuries receive immediate triage assessment.
- Pre-placement exams and DOT physicals are seen on a walk-in basis. Exam forms are provided, or you may use your company's specific forms.
- Working with CMC requires no contract. Our fees are competitive and adhere to the applicable state workers' compensation fee guidelines.

After Hours Emergency Network Provider

Report to:
Mercy Hospital Emergency Department 301 Saint Paul Pl.
Baltimore, MD 21202 410-332-9477

REQUEST FOR SERVICES

INJURY CARE

Employee's Name _____Social Security # _____

Date of Request _____ Date of Birth _____

Home Phone # _____ Work Phone # _____

Address _____

Occupation/Job Title _____

Scheduled Date of Exam _____Time _____Network Site _____

Authorized by _____ Agency Phone # _____

Agency _____ Agency Fax # _____

SERVICE REQUESTED:

__ Injury care Date of Incident: _____ Injury: _____

__ Injury Evaluation/Second Opinion/Periodic Injury Evaluation (P.I.E.)

The following should be forwarded to the center or accompany the patient to the center at time of appointment:

A. Employee's position description/job description
B. Must call in First Report of Injury for Work Injury/Illness to Injured Workers' Insurance Fund

---

********** (Employee Section) **********

This will authorize the State Medical Director's Office to release all pertinent information with regard to the diagnosis, evaluation, treatment, and prognosis of the condition being evaluated to my employer, the insurance carrier or the agents. This also authorizes The State Medical Director's Office to obtain all pertinent information with regard to the diagnosis, evaluation, treatment, and prognosis of the condition being evaluated and/or treated.

Employee's Signature _____ Date _____

(OVER)

Provider Section

Diagnosis _____ Health Classification with respect to physical/mental requirements of the job:

l. _____ Recommended/regular activities

Health-related condition(s) exists which may interfere with performance of essential job functions:

Current Activity Status:

Lifting Limits (weight range and frequency) _____
Sitting (needs and limits) _____
Mobility Impairment (specify) _____
Vision/Hearing Impairment (specify) _____
Mental Health Needs _____
Travel (specify needs and limits) _____
Working Hours _____

4. _____Deferred/pending - further evaluation by _____

5. _____Does not meet US DOT requirements/essential job functions

6. _____Other/ Comments

The above activity restrictions expire: _____

The above health classification was explained to patient: __ yes ___no

Employee's Signature _____ Date _____

Examining Professional (print) _____

Examining Professional's Signature _____ Date _____

This assessment was performed _ with __ without a written statement describing the essential functions of the job.

A copy of this form completed by the provider should be placed in a sealed envelope and returned to the designated agency contact.

Time In w/Initials _____ Time Out w/Initials _____