INSTRUCTIONS
COMPLETING EMPLOYEE FIRST REPORT OF INJURY

1. Employee or an individual acting on the employee's behalf completes the Employee First Report of Injury Form.

2. Supervisor or another responsible administrative official completes the Supervisor's Report of Injury and Concentra Form.

3. **INJURED EMPLOYEES SHOULD BE SEEN ON A WALK-IN BASIS WITHIN 3 WORKING DAYS OF THE ACCIDENT IN ANY OF NINE CONCENTRA MEDICAL CENTERS THROUGHOUT THE STATE. THE EMPLOYEE MAY CARRY OR THE PERSONNEL OFFICE MAY FAX THE REFERRAL FORM TO THE MEDICAL CENTER.**

NOTE:

**THE COMPLETED FIRST REPORT OF INJURY PACKET SHOULD BE GIVEN TO JENNIFER ENGLISH IN THE OFFICE OF HUMAN RESOURCES WITHIN 3 WORKING DAYS AFTER THE INJURY OCCURS. THE INFORMATION MAY BE EMAILED TO JENNIFER AT JENNIFER.ENGLISH@MARYLAND.GOV. FAILURE TO PROVIDE THE PROPER DOCUMENTATION WITHIN THE ESTABLISHED TIME FRAME COULD RESULT IN A DELAY OR DISAPPROVAL OF ACCIDENT LEAVE. FOR ANY ADDITIONAL QUESTIONS, PLEASE CONTACT JENNIFER ENGLISH AT 410-767-5532.**
Employee's Report of Injury

(To be completed by the employee only.)

Employee's name: ________________________________________________________ Male__Female__

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: ____________________________________________________________________________________

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# ____________________________

Name(s) of witness(es): ___________________________ Phone# ____________________________

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: __________________
Accident Witness Statement
(To be completed by accident witness)

Injured employee's name: ______________________________________________________________

Name of witness: _________________________________________________________________

Job title of witness: ___________________________ How long employed here? ______

Home address of witness: ____________________________________________________________

City: ___________________________ State: _____ Zip Code: ________________

Location of accident: ________________________________________________________________

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: __________________________________________________________

Signature of Witness: ________________________________________________________________ Date: ___________________________
### Supervisor’s Accident Investigation

(To be completed by the employee’s supervisor or other responsible administrative official)

<table>
<thead>
<tr>
<th>Location where accident occurred</th>
<th>Employer’s Premises: □ Yes □ No</th>
<th>Date of accident or illness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Job site: □ Yes □ No</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Who was injured?</th>
<th>□ Employee □ Non-Employee</th>
<th>Time of accident a.m. or p.m.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Length of time with firm</th>
<th>Job title or occupation</th>
<th>Name of dept. normally assigned to</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

| Property/equipment owned by: | |
|-----------------------------| |

<table>
<thead>
<tr>
<th>What property/equipment was damaged?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>What was employee doing when injury/illness occurred?</th>
<th>What machine or tool was being used?</th>
<th>What type of operation?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>How did injury/illness occur?</th>
<th>List all objects and substances involved.</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Part of body affected/injured?</th>
<th>Any prior physical conditions? If so, what?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Yes □ No</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Nature and extent of injury/illness and property damaged (be specific)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

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
|-------------------|------------------------|--------|--------

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Form may be copied as needed
MARYLAND LOCATIONS

CONCENTRA MEDICAL CENTERS

THE OCCUPATIONAL HEALTHCARE SOLUTION

1 Arbutus
   AFTER HOURS FACILITY
   1419 Kecht Avenue
   Baltimore, MD 21227
   410-247-9595
   FAX: 410-247-7553
   Hours: 7:00 a.m. Monday - 12:00 noon Saturday (24 Hours)

2 BWI
   890 Airport Park Road
   Suite 100
   Glenburnie, 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)
REQUEST FOR SERVICES

INJURY CARE (CONT'D.)

Provider Section

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

1. _______ Recommended/regular activities

2. _______ Recommended pending ancillary testing

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 ___________________________

10/24/00