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 THE CONCENTRA MEDICAL SERVICES (CMC) LOCATIONS THROUGHOUT THE STATE. THE EMPLOYEE MAY CARRY OR THE PERSONNEL OFFICE MAY FAX THE AUTHORIZATION FORM TO THE MEDICAL CENTER.**

NOTE:

THE COMPLETED FIRST REPORT OF INJURY PACKET SHOULD BE GIVEN TO ASHLEE CRISE IN THE OFFICE OF HUMAN RESOURCES WITHIN 3 WORKING DAYS AFTER THE INJURY OCCURS. THE INFORMATION MAY BE EMAILED TO ASHLEE AT ASHLEE.CRISE@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 ASHLEE CRISE AT 410-767-6411.

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: _____

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

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

Concentra®

State of Maryland

Authorization for Examination or Treatment

(Employee/Applicant Must Present Photo ID at Time of Service)

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

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

_____

Agency 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 (Recert ONLY)

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

☐ Initial Workability ☐ Follow-up Workability ☐Other: _____

Substance Abuse Testing

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

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

☐ Other:_____ ☐ Direct Observation Required

Reason for Substance Abuse Testing

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

☐ Follow-up ☐ Return to Duty ☐ Other _____

Psychological Services

Please Provide Employee/Applicant Phone # and Zip Code -AND- DAC's Email Address

☐ Psychological Testing (Psych Eval) ☐ SAP ☐ Critical Incident Management

Other Services

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

☐ Chest X-ray ☐ Vaccinations:_____ ☐ Chromium

☐ Other:_____

Special instructions/comments_____

_____