EMPLOYEE'S CLAIM
WORKERS' COMPENSATION COMMISSION

10 East Baltimore Street
Baltimore, Maryland 21202-1641
BALTIMORE PHONE 410-864-5100
TOLL FREE 1-800-492-0479 IN MARYLAND
TTY USERS CALL VIA MARYLAND RELAY

DATE STAMP

DO NOT WRITE IN CLAIM NUMBER BOX

CLAIM NUMBER

PERSONAL INFORMATION

1. Claimant First Name | 2. Middle Initial | 3. Claimant Last Name

4. Phone Number | 5. Street Address

6. City | 7. County | 8. State | 9. Zip Code

10. Social Security Number | 11. Sex (M / F) | 12. Date of Birth | 13. Marital Status (M / S) | 14. Gross Wages Per Week | 15. Paid full wages for day? (YES / NO)

16. What Is Your Regular Work? | 17. What Was Your Work When Injured?

EMPLOYER INFORMATION

18. Full and correct business name of your employer

19. Employer Phone Number | 20. Complete Address

21. City | 22. State | 23. Zip Code | 24. Notice of Injury Given? (YES / NO)

25. Nature of Employer's business | 26. Location where accident occurred

27. Whom did you notify of the accident? | 28. First Day Not Worked | 29. Occupat. Disease? (Yes / No) | 30. Date of accident/occupational disease disablement | Time AM PM

31. Describe how accidental injury occurred

OR

32. Describe how occupational disease occurred

NOTE: Failure to disclose information or giving false information, including information regarding any work related activity or return to work either before or after an award of benefits, may subject you to fines, imprisonment, or both, and disqualify you from receiving benefits. A CLAIMANT'S FAILURE TO COMPLETE THIS FORM IN COMPLIANCE WITH THE DIRECTIONS ON PAGE 3 MAY RESULT IN THE CLAIM BEING REJECTED. TO EXPEDITE YOUR CLAIM, YOU MAY SEND A COPY OF THE COMPLETED FORM TO YOUR EMPLOYER.

ACCIDENT / OCCUPATIONAL DISEASE INFORMATION

33. What member of your body was injured?

34. Amputation Required? (YES / NO) | 35. Employer requested to provide medical care? (YES / NO) | 36. Medical care provided? (YES / NO) | 37. Date returned to Work

38. Attending Physician Name | 39. Street Address

40. Apt. / Suite | 41. City | 42. State | 43. Zip Code

44. If you were in a hospital – Hospital Name | 45. Street Address

46. Apt. / Suite | 47. City | 48. State | 49. Zip Code

50. If Health Insurance used, give name of Insurance Co.

I hereby make claim for compensation for an injury resulting in my disability due to an accident (or disease) arising out of and in the course of my employment, and in support of it make the foregoing statement of facts. I hereby certify that the information I have given is accurate and that I have read the information on this form.

SIGNATURE | DATE

DO NOT WRITE IN SPACE BELOW

INS. CO. | ATTY | INS. CO. 2 | ATTY | EMPLOYER | EMP. ATTY | CLMT. ATTY