

If you haven't filled out one of these,  
 you haven't filed a claim

**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**

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. Occupational Disease?  YES  NO 30. Date of accident/occupational disease disablement  AM  PM  Time

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.

**CLAIM 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: \_\_\_\_\_

Email  Received:

