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

CLAIM NUMBER:

BALTIMORE PHONE 410-864-5100
TOLL FREE 1-800-492-0479 IN MARYLAND
TTY USERS CALL VIA MARYLAND RELAY

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 MD
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 MD
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 MD
43. Zip Code
44. If you were in a hospital – Hospital Name
45. Street Address
46. Apt. / Suite
47. City
48. State MD
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:

E10222957