EMPLOYEE'S CLAIM

WORKERS' COMPENSATION COMMISSION
10 East Baltimore Street
Baltimore, Maryland 21202-16415

TOLL FREE 1-800-492-0479 Outside Baltimore
BALTIMORE PHONE 410-864-5100
BALTIMORE TTY FOR DEAF 410-383-7555

CLAIM NUMBER:

PERSONAL INFORMATION

1. Claimant First Name
2. Middle Initial
3. Claimant Last Name
4. Phone Number
5. Mailing 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. Complete Address
20. Employer Phone Number
21. City
22. State
23. Zip Code
24. Nature of Employer's business
25. Location where accident occurred
26. Notice of Injury Given? ☐ YES ☐ NO
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

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 regarding any work-related activity or return to work may subject you to fines, imprisonment or both and disqualify you from receiving benefits. **You MUST complete all required information (fields), "Submit" the data via the button on the form, sign the form and mail it to the Commission at the address on the form. You may not alter or add information to the printed form. Failure to follow all instructions may result in a return of the form in the processing or non-processing of your claim.** Print a copy for your records and a copy to supply to your employer and/or their insurance carrier.

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. Address
40. Apt. / Suite
41. City
42. State
43. Zip Code
44. If you were in a hospital – Hospital Name
45. Address
46. Apt. / Suite
47. City
48. State
49. Zip Code

58. 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.
READ 2nd PAGE BEFORE SIGNING. KEEP DUPLICATE COPY FOR YOUR RECORDS.

Claimant Signature: ____________________

Date: ____________________

Email Address:

Received: