

EMPLOYEE'S CLAIM

WORKERS' COMPENSATION COMMISSION

10 East Baltimore Street
Baltimore, Maryland 21202-16415

CLAIM NUMBER: _____

TOLL FREE 1-800-492-0479 Outside Baltimore

BALTIMORE PHONE 410-864-5100

BALTIMORE TTY FOR DEAF 410-383-7555

PERSONAL INFORMATION

1. Claimant First Name <input type="text"/>	2. Middle Initial <input type="text"/>	3. Claimant Last Name <input type="text"/>	4. Phone Number <input type="text"/>		
5. Mailing Address <input type="text"/>	6. City <input type="text"/>	7. County <input type="text"/>	8. State <input type="text"/>	9. Zip Code <input type="text"/>	
10. Social Security Number <input type="text"/>	11. Sex <input type="checkbox"/> M <input type="checkbox"/> F	12. Date of Birth <input type="text"/>	13. Marital Status <input type="checkbox"/> M <input type="checkbox"/> S	14. Gross Wages Per Week \$ <input type="text"/> . <input type="text"/>	15. Paid full wages for Day? <input type="checkbox"/> YES <input type="checkbox"/> NO
16. What Is Your Regular Work? <input type="text"/>	17. What Was Your Work When Injured? <input type="text"/>				

EMPLOYER INFORMATION

18. Full and correct business name of your Employer <input type="text"/>	20. Employer Phone Number <input type="text"/>		
19. Complete Address <input type="text"/>			
21. City <input type="text"/>	22. State <input type="text"/>	23. Zip Code <input type="text"/>	26. Notice of Injury Given? <input type="checkbox"/> YES <input type="checkbox"/> NO
24. Nature of Employer's business <input type="text"/>	25. Location where accident occurred <input type="text"/>		
27. Whom did you notify of the accident? <input type="text"/>	28. First Day Not Worked <input type="text"/>	29. Occupational Disease? <input type="checkbox"/> YES <input type="checkbox"/> NO	30. Date of accident/occupational disease disablement <input type="text"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Time <input type="text"/>
31. Describe how accidental injury occurred <input type="text"/>	32. Describe how occupational disease occurred <input type="text"/>		

OR

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? <input type="text"/>	34. Amputation required? <input type="checkbox"/> YES <input type="checkbox"/> NO	35. Employer requested to provide medical care? <input type="checkbox"/> YES <input type="checkbox"/> NO	36. Medical care provided? <input type="checkbox"/> YES <input type="checkbox"/> NO	37. Date returned to Work <input type="text"/>	
38. Attending Physician Name <input type="text"/>	39. Address <input type="text"/>	40. Apt. / Suite <input type="text"/>	41. City <input type="text"/>	42. State <input type="text"/>	43. Zip Code <input type="text"/>
44. If you were in a hospital - Hospital Name <input type="text"/>	45. Address <input type="text"/>	46. Apt. / Suite <input type="text"/>	47. City <input type="text"/>	48. State <input type="text"/>	49. Zip Code <input type="text"/>
			58. If Health Insurance used, give name of Insurance Co. <input type="text"/>		

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.

Claimant Signature: _____

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

Date: _____

Email Address:

Received: _____