

MWCC - WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)		CARRIER/ADMINISTRATOR CLAIM NUMBER		REPORT PURPOSE CODE
		JURISDICTION	JURISDICTION CLAIM NUMBER	
		INSURED REPORT NUMBER		
SIC CODE	EMPLOYER FEIN	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION # PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO)		POLICY PERIOD TO	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
		<input type="checkbox"/> CHECK IF APPROPRIATE SELF INSURANCE	
CARRIER FEIN	POLICY/SELF-INSURED NUMBER		ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)		SEX	MARITAL STATUS		OCCUPATION/JOB TITLE
		<input type="checkbox"/> MALE (M) <input type="checkbox"/> FEMALE (F) <input type="checkbox"/> UNKNOWN (U)	<input type="checkbox"/> UNMARRIED/SINGLE/DIVORCED (U) <input type="checkbox"/> MARRIED (M) <input type="checkbox"/> SEPARATED (S) <input type="checkbox"/> UNKNOWN (K)	EMPLOYMENT STATUS	
PHONE		# OF DEPENDENTS	NCCI CLASS CODE		
RATE	PER: <input type="checkbox"/> DAY <input type="checkbox"/> MONTH <input type="checkbox"/> OTHER:	#DAYS WORKED WEEK	FULL PAY FOR DAY OF INJURY?		<input type="checkbox"/> YES <input type="checkbox"/> NO
			DID SALARY CONTINUE?		<input type="checkbox"/> YES <input type="checkbox"/> NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK	<input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	<input type="checkbox"/> AM <input type="checkbox"/> PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
CONTACT NAME/PHONE NUMBER			TYPE OF INJURY/ILLNESS		PART OF BODY AFFECTED		
DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO			TYPE OF INJURY/ILLNESS CODE		PART OF BODY AFFECTED CODE		
COUNTY WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED				ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED				WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? WERE THEY USED?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL (NAME & ADDRESS)	INITIAL TREATMENT NO MEDICAL TREATMENT (0) <input type="checkbox"/> MINOR: BY EMPLOYER (1) <input type="checkbox"/> MINOR CLINIC/HOSP (2) <input type="checkbox"/> EMERGENCY CARE (3) <input type="checkbox"/> HOSPITALIZED > 24 HRS (4) <input type="checkbox"/> FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED (5) <input type="checkbox"/>
WITNESSES (NAME & PHONE #)			
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER

WORKERS' COMPENSATION COMMISSION

Statement of Wage Information

The information below is provided pursuant to COMAR 14.09.01.07 and LE, §9-602(a)(2), Annotated Code of Maryland.

This form should be submitted before the consideration date or to provide updated wage information. When a claim has already been filed, a copy of this form shall be sent to the Workers' Compensation Commission and the claimant or his/her attorney.

Injured Employee Name: _____ **Date:** _____

WCC Claim Number: _____

*Was this employee provided free rent, lodging, board, tips or other allowances in addition to the above earnings?
If "yes", the weekly or bi-weekly value must be included in the "Other Allowances" Column.

When the employee is paid weekly, complete each row for the most recent 14 weeks where wages were paid. If paid alternate weeks please enter in the clear, even-numbered rows. If paid on any other schedule, please use the worksheet on page 2 to calculate the average weekly wage. If less than 14 weeks were worked by the employee, use the worksheet on page 2.

Week #	Week Ending (MM/DD/YYYY)	Days Worked	Gross Wages including overtime	Other Allowances*	Total Amount Paid
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
TOTALS					

TOTAL _____ divided by number weeks worked (where wages are paid/indicated) **14** = **Average Weekly Wage**

CERTIFICATION OF SERVICE -

I hereby certify that on the above date, a copy of this Statement of Wage form was mailed to the Workers' Compensation Commission and the claimant or his/her attorney.

SUBMITTED BY:

Name _____ Signature _____

Company _____ Title _____

Street _____

City _____ State _____ ZIP Code _____

Telephone _____ Email _____

10 East Baltimore Street · Baltimore, Maryland 21202-1641

410-864-5100 · Email: info@wcc.state.md.us · Web: <http://www.wcc.state.md.us>


WORKERS' COMPENSATION COMMISSION
Statement of Wage Information

CALCULATION OF AVERAGE WEEKLY WAGE WHEN CLAIMANT
IS PAID OTHER THAN WEEKLY OR BI-WEEKLY
(Monthly, Semi-Monthly or other, attach details)

A. Inclusive dates used in wage statement _____ to _____

B. Number of days used in calculation _____
(Minimum 98 days to capture 14 weeks)

C. Gross wages _____
(including overtime, free rent, lodging, board,
tips & other allowances)

D. Daily Rate ($C \div B$) _____

E. Average Weekly Wage ($D \times 7$) _____

Average Weekly Wage (E) = _____
Please enter this amount on page 1
as Average Weekly Wage

WORKERS' COMPENSATION in Maryland

LA COMPENSACIÓN DEL TRABAJADOR en Maryland

Job Related Accidental Personal Injury or Occupational Disease?

If you are disabled and unable to work for more than three (3) days, your employer's workers' compensation insurance company may pay your medical bills and other expenses and replace two-thirds (2/3) of your salary (limited to the maximum set by law).

If you are injured on the job:

1. Notify your employer or supervisor at once. You cannot receive full benefits unless your employer knows you are injured.
2. Tell the doctor who treats you that you were hurt on the job.
3. Complete an Employee's Claim Form C-1 (available by phone or on the Commission's website) and send it to us as soon as possible.

Note: Withholding information or giving false information about any work-related activity or return to work could prevent you from receiving benefits and may subject you to fines, imprisonment or both.

Employer/Empleador _____

Business Address/Dirección _____

City/State/Zip _____

Ciudad/Estado/Código Postal _____

Federal Employer ID (FEIN) _____

Identificación Federal Del Empleador _____

Telephone Number/Número Telefónico _____

Insurance Company Name _____

La Compañía de Seguro _____

Insurance Company Telephone _____

Telefónico de la Compañía de Seguro _____

MD WCC Form C-24 11/2007

¿Accidentes por lesión/daño corporal relacionados con el Empleo o Enfermedad Profesional?

Si usted se encuentra incapacitado o inhabilitado para trabajar por más de tres días, el seguro de trabajadores que tienen las compañías pudiera cubrir las facturas médicas y otros gastos relacionados. También le compensarían 2/3 de sus ingresos (Hasta un monto máximo estipulado por la ley).

Si usted sufre una lesión en el trabajo, debe:

1. Informarle a su empleador o supervisor de inmediato. No podría recibir todos sus beneficios a menos que su empleador fuere notificado que sufrió una lesión.
2. Informarle al médico quien le administre tratamiento que usted se lesionó en su trabajo.
3. Llenar el formulario Employee's Claim Form C-1 (disponible consultando la página del Internet para el Workers' Compensation o solicitándolo uno por teléfono). Diligenciarlo para que las oficinas del Workers' Compensation lo reciban lo antes posible.

Aviso: El suministrar información falsa u ocultar información sobre cualquier actividad relacionada con su trabajo o relacionada con su regreso al trabajo, pudiera afectar los beneficios que recibiera o pudiera acarrearle multas, encarcelamiento o ambas.

Maryland Workers' Compensation Commission

10 East Baltimore Street, Baltimore, Maryland 21202-1641

(410) 864-5100 / Outside Baltimore (800) 492-0479

Webpage - <http://www.wcc.state.md.us> / TTY Users - 711 in Maryland or (800) 735-2258

This notice must be printed on 8.5" X 14" gold or yellow paper, display complete employer information and be posted in a conspicuous location at each work site or location in accordance with COMAR 14.09.01.02 and 14.09.01.03.