WORKERS COMPENSATION FIRST REPORT OF INJURY OR ILLNESS

GENERAL

EMPLOYER

Name: Select County Board of Education
Address:
City:
State: MD **Zip Code:**
Industry Code: 8211 **Employer FEIN:**

CLAIM NUMBER | **REPORT PURPOSE CODE**
JURISDICTION | **JURISDICTION CLAIM NUMBER**
Report #: Enter Your Report Number

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)
Location: Enter Location Name
Address: Enter Address
City: Enter City **State:** MD **Zip Code:** ENTER

Location Number Enter Loc. No.
Phone #:

CARRIER / CLAIMS ADMIN

CARRIER (NAME, ADDRESS & PHONE NO)
MD Assoc. of Boards of Education
Workers' Compensation Group Self Ins. Fund
621 Ridgely Ave., Suite 300
Annapolis, MD 21401

Policy Period: 7/1/2005 to 6/30/2006

CHECK IF SELF-INSURANCE ☒

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE #)
MABE Claims Unit
621 Ridgely Ave., Suite 301
Annapolis, MD 21401
Fax: 410-841-2669

EMAIL THIS FORM TO: wcclaims@mabe.org

CARRIER FEIN	**POLICY/SELF-INSURANCE NUMBER**	**ADMINISTRATOR FEIN**

AGENT NAME & CODE NUMBER

EMPLOYEE

NAME (LAST, FIRST, MIDDLE)	**DATE OF BIRTH**	**SOC. SEC. #**	**DATE HIRED**	**STATE HIRED**
				MD

Address:
City:
State: MD **Zip Code:**

SEX SELECT
OCCUPATION/JOB TITLE ENTER
MARITAL STATUS SELECT
EMPLOYMENT STATUS SELECT

TELEPHONE (INCL. AREA CODE) ENTER PHONE #
 # OF DEPENDANTS ENTER #
NCCI CLASS CODE NCCI CLASS CODE

WAGE

RATE	**PER PERIOD**	**# OF DAYS PER WEEK**	
ENTER	SELECT	ENTER	**FULL PAY FOR THE DAY OF THE INJURY?** ☐ YES ☐ NO **DID SALARY CONTINUE?** ☐ YES ☐ NO

OCCURRENCE

TIME EMPLOYEE BEGAN WORK	**DATE OF INJURY/ ILLNESS**	**TIME OF OCCURRENCE**	**LAST WORK DATE**	**DATE EMPLOYER NOTIFIED**	**DATE DISABILITY BEGAN**
AM		AM			

CONTACT NAME AND PHONE ENTER NAME ENTER PHONE #
LIST TYPE OF INJURY OR ILLNESS
LIST PART OF BODY AFFECTED

DID EXPOSURE OCCUR ON EMPLOYERS PREMISES? ☐ YES ☐ NO
TYPE OF INJURY ILLNESS CODE SELECT ILLNESS or SELECT INJURY
PART OF BODY AFFECTED CODE SELECT BODY PART SELECT SIDE OF BODY

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED
ENTER YOUR DEPARTMENT OR LOCATION NAME

ALL EQUIP., MATERIALS, 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.
Employee Select ENTER

DATE RETURNED TO WORK
IF FATAL GIVE DATE OF DEATH
WERE SAFEGUARDS OR SAFETY EQUIP PROVIDED? PICK
WERE THEY USED? PICK
CAUSE OF INJURY CODE PICK GENERAL CAUSE
ENTER ANY ADDITIONAL COMMENTS

TREATMENT

PHYSICIAN/HEALTH CARE PROVIDER
Name:
Address:
City:
State: MD **Zip Code:**

HOSPITAL
Name:
Address:
City:
State: MD **Zip Code:**

INITIAL TREATMENT SELECT

IS FUTURE LOST TIME ANTICIPATED? ☐ YES ☐ NO

OTHER

WITNESS NAME: **PHONE #:**

DATE ADMINISTRATOR NOTIFIED	**DATE PREPARED**	**PREPARER'S NAME & TITLE**	**PREPARER'S PHONE #**
		ENTER NAME ENTER TITLE	

 SEE BACK FOR IMPORTANT INFORMATION/OSHA REQUIREMENTS