

INSTRUCTIONS

COMPLETING EMPLOYEE FIRST REPORT OF INJURY

1. Employee or an individual acting on the employee's behalf completes the Employee First Report of Injury Form.
2. Supervisor or another responsible administrative official completes the Supervisor's Report of Injury and Concentra Form.
3. **INJURED EMPLOYEES SHOULD BE SEEN ON A WALK-IN BASIS WITHIN 3 WORKING DAYS OF THE ACCIDENT IN ANY OF NINE CONCENTRA MEDICAL CENTERS THROUGHOUT THE STATE. THE EMPLOYEE MAY CARRY OR THE PERSONNEL OFFICE MAY FAX THE REFERRAL FORM TO THE MEDICAL CENTER.**

NOTE:

THE COMPLETED FIRST REPORT OF INJURY PACKET SHOULD BE GIVEN TO JENNIFER ENGLISH IN THE OFFICE OF HUMAN RESOURCES WITHIN 3 WORKING DAYS AFTER THE INJURY OCCURS. THE INFORMATION MAY BE EMAILED TO JENNIFER AT JENNIFER.ENGLISH@MARYLAND.GOV. FAILURE TO PROVIDE THE PROPER DOCUMENTATION WITHIN THE ESTABLISHED TIME FRAME COULD RESULT IN A DELAY OR DISAPPROVAL OF ACCIDENT LEAVE. FOR ANY ADDITIONAL QUESTIONS, PLEASE CONTACT JENNIFER ENGLISH AT 410-767-5532.

Accident Witness Statement

(To be completed by accident witness)

Injured employee's name: _____
Last First Middle

Name of witness: _____ Ph# _____
Last First Middle

Job title of witness: _____ How long employed here? _____

Home address of witness: _____

City: _____ State: _____ Zip Code: _____

Location of accident: _____
Address/Name of building Area (bathroom, etc.)

Date of accident: _____ Time of accident: _____

Describe fully how accident occurred: (including events that occurred immediately before the accident):

Describe bodily injury sustained (be specific about body part(s) affected):

Recommendation on how to prevent this accident from recurring: _____

Name of Witness's Supervisor: _____ Ph# _____
Last First

Signature of Witness: _____ Date: _____

Supervisor's Accident Investigation

(To be completed by the employee's supervisor or other responsible administrative official)

Location where accident occurred		Employer's Premises: <input type="checkbox"/> Yes <input type="checkbox"/> No Job site: <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of accident or illness
Who was injured?			<input type="checkbox"/> Employee <input type="checkbox"/> Non-Employee	
Length of time with firm	Job title or occupation	Name of dept. normally assigned to	How long has employee worked at job where injury or illness occurred? Property/equipment owned by:	
What property/equipment was damaged?				
What was employee doing when injury/illness occurred? What machine or tool was being used? What type of operation?				
How did injury/illness occur? List all objects and substances involved.				
Part of body affected/injured?		Any prior physical conditions? If so, what? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Nature and extent of injury/illness and property damaged (be specific)				

PLEASE INDICATE ALL OF THE FOLLOWING WHICH CONTRIBUTED TO THE INJURY OR ILLNESS

- | | | |
|--|--|--|
| <input type="checkbox"/> Failure to lockout | <input type="checkbox"/> Failure to secure | <input type="checkbox"/> Horseplay |
| <input type="checkbox"/> Improper dress | <input type="checkbox"/> Improper guarding | <input type="checkbox"/> Improper instruction |
| <input type="checkbox"/> Improper maintenance | <input type="checkbox"/> Improper protective equipment | <input type="checkbox"/> Inoperative safety device |
| <input type="checkbox"/> Lack of training or skill | <input type="checkbox"/> Operating without authority | <input type="checkbox"/> Physical or mental impairment |
| <input type="checkbox"/> Poor housekeeping | <input type="checkbox"/> Poor ventilation | <input type="checkbox"/> Unsafe arrangement or process |
| <input type="checkbox"/> Unsafe equipment | <input type="checkbox"/> Unsafe position | <input type="checkbox"/> Other _____ |

Supervisor's corrective action to ensure this type of accident does not recur: _____

Was employee trained in the appropriate use of Personal Protective Equipment/Proper safety procedures? _____ Yes _ No __

Was employee cautioned for failure to use Personal Protective Equipment/Proper safety procedures? _____ Yes _ No __

Did employee promptly report the injury/illness? _____ Yes _ No __

Is there modified duty available? _____ Yes _ No __

Supervisor's name _____ Supervisor's signature _____ Phone# _____ Date _____

MARYLAND LOCATIONS

CONCENTRA

MEDICAL CENTERS

THE OCCUPATIONAL HEALTHCARE SOLUTION

1 Arbutus

AFTER HOURS FACILITY
1419 Knecht Avenue
Baltimore, MD 21227

410-247-9595

FAX: 410-247-7553

Hours: 7:00 a.m. Monday -
12:00 noon Saturday
(24 Hours)

2 BWI

890 Airport Park Road
Suite 100
Glen Burnie, MD 21061

410-553-0110

FAX: 410-553-0197

Hours: 7:30 a.m. - 5:00 p.m.
Monday - Friday

3 Columbia

6656 Dobbin Road
Columbia, MD 21045
410-381-1330

FAX: 410-381-5585

Hours: 8:00 a.m. - 5:00 p.m.
Monday - Friday

4 Dundalk

Holabird Industrial Park
1833 Portal St.
Baltimore, MD 21224
410-633-3600

FAX: 410-633-3604

Hours: 8 a.m. - 5:00 p.m.
Monday - Friday

5 Inner Harbor

100 South Charles St., Suite 150
Baltimore, MD 21201
410-752-3010

FAX: 410-539-7023

Hours: 8:00 a.m. - 5:00 p.m.
Monday - Friday

6 Rosedale

8101 Pulaski Hwy., Suite H. I, J
Baltimore, MD 21237
410-687-6462

FAX: 410-687-2261

Hours: 7:00 a.m. - 7 p.m.

Monday - Friday

7:00 a.m. - 12:00 noon

Saturday

7 Lanham

4451 G Parliament Place
Lanham, MD 20706
301-459-9113

FAX: 301-459-1214

Hours: 7:00 a.m. - 8:00 p.m.

Monday - Friday

7:00 a.m. - 12:00 noon

Saturday

8 Jessup

7377 Washington Blvd., Ste. 101-102
Elkridge, MD 21075
410-379-3051

FAX: 410-379-3074

Hours: 8 a.m. - 5:00 p.m.

Monday - Friday

9 Timonium

1840 York Road, Ste. E.
Timonium, MD 21093
410-252-4015

FAX: 410-252-7410

Hours: 8 a.m. - 5:00 p.m.

Monday - Friday

Center Information

- All patients are seen on a walk-in basis. Work-related injuries receive immediate triage assessment.
- Pre-placement exams and DOT physicals are seen on a walk-in basis. Exam forms are provided, or you may use your company's specific forms.
- Working with CMC requires no contract. Our fees are competitive and adhere to the applicable state workers' compensation fee guidelines.

After Hours Emergency Network Provider

Report to:

Mercy Hospital Emergency Department 301 Saint Paul Pl.
Baltimore, MD 21202 410-332-9477

REQUEST FOR SERVICES

INJURY CARE

Employee's Name _____ Social Security # _____

Date of Request _____ Date of Birth _____

Home Phone # _____ Work Phone # _____

Address _____

Occupation/Job Title _____

Scheduled Date of Exam _____ Time _____ Network Site _____

Authorized by _____ Agency Phone # _____

Agency _____ Agency Fax # _____

SERVICE REQUESTED:

Injury care Date of Incident: _____ Injury: _____

Injury Evaluation/Second Opinion/Periodic Injury Evaluation (P.I.E.)

The following should be forwarded to the center or accompany the patient to the center at time of appointment:

- A. Employee's position description/job description
- B. Must call in First Report of Injury for Work Injury/Illness to Injured Workers' Insurance Fund

***** (Employee Section) *****

This will authorize the State Medical Director's Office to release all pertinent information with regard to the diagnosis, evaluation, treatment, and prognosis of the condition being evaluated to my employer, the insurance carrier or the agents. This also authorizes The State Medical Director's Office to obtain all pertinent information with regard to the diagnosis, evaluation, treatment, and prognosis of the condition being evaluated and/or treated.

Employee's Signature _____ Date _____

(OVER)

Provider Section

Diagnosis _____ Health Classification with respect to physical/mental requirements of the job:

- 1. _____ Recommended/regular activities
- 2. _____ Recommended pending ancillary testing

Health-related condition(s) exists which may interfere with performance of essential job functions:

Current Activity Status:

Lifting Limits (weight range and frequency) _____
 Sitting (needs and limits) _____
 Mobility Impairment (specify) _____
 Vision/Hearing Impairment (specify) _____
 Mental Health Needs _____
 Travel (specify needs and limits) _____
 Working Hours _____

- 4. _____ Deferred/pending - further evaluation by _____
- 5. _____ Does not meet US DOT requirements/essential job functions
- 6. _____ Other/ Comments

The above activity restrictions expire: _____

The above health classification was explained to patient: __ yes __no

Employee's Signature _____ Date _____

Examining Professional (print) _____

Examining Professional's Signature _____ Date _____

This assessment was performed _ with _ without a written statement describing the essential functions of the job.

A copy of this form completed by the provider should be placed in a sealed envelope and returned to the designated agency contact.

Time In w/Initials _____

Time Out w/Initials _____