EMPLOYEE'S CLAIM
WORKERS' COMPENSATION COMMISSION

10 East Baltimore Street
Baltimore, Maryland 21202-1641
BALTIMORE PHONE 410-864-5100
TOLL FREE 1-800-492-0479 IN MARYLAND
TTY USERS CALL VIA MARYLAND RELAY

DATE STAMP

DO NOT WRITE IN CLAIM NUMBER BOX

CLAIM NUMBER

PERSONAL INFORMATION

1. Claimant First Name | 2. Middle Initial | 3. Claimant Last Name

4. Phone Number | 5. Street 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. Employer Phone Number | 20. Complete Address

21. City | 22. State | 23. Zip Code | 24. Notice of Injury Given? YES NO

25. Nature of Employer's business | 26. Location where accident occurred

27. Whom did you notify of the accident? | 28. First Day Not Worked | 29. Occupat. 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, including information regarding any work related activity or return to work either before or after an award of benefits, may subject you to fines, imprisonment, or both, and disqualify you from receiving benefits. A CLAIMANT'S FAILURE TO COMPLETE THIS FORM IN COMPLIANCE WITH THE DIRECTIONS ON PAGE 3 MAY RESULT IN THE CLAIM BEING REJECTED. TO EXPEDITE YOUR CLAIM, YOU MAY SEND A COPY OF THE COMPLETED FORM TO YOUR EMPLOYER.

ACCIDENT / OCCUPATIONAL DISEASE 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. Street Address

40. Apt. / Suite | 41. City | 42. State | 43. Zip Code

44. If you were in a hospital – Hospital Name | 45. Street Address

46. Apt. / Suite | 47. City | 48. State | 49. Zip Code

50. 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.

SIGNATURE | DATE

DO NOT WRITE IN SPACE BELOW

INS. CO. | ATTY | INS. CO. 2 | ATTY | EMPLOYER | EMP. ATTY | CLMT. ATTY

MARYLAND WORKERS' COMPENSATION COMMISSION
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Pursuant to Labor and Employment Article, §§ 9-709, 9-710, and 9-711, Annotated Code of Maryland, this authorization must be signed and filed with the Workers' Compensation Commission of Maryland in conjunction with any claim for workers' compensation benefits.

A. Person Covered by Authorization

This document authorizes the disclosure of protected health information regarding:

_____ _____

Name/Claimant Date of Birth

B. Purpose of Disclosure

This document authorizes the disclosure of protected health information for the purpose of processing, adjudicating and resolving workers' compensation claims.

C. Entities Authorized to Make Disclosure

This document authorizes any health plan, physician, health care professional, dentist, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf to disclose my protected health information consistent with this directive.

D. Entities Authorized to Receive Protected Health Information

This document authorizes the disclosure of my protected health information to the following entities and their agents: my attorney, my employer, and my employer's workers' compensation insurer.

E. Information to be Disclosed

This document authorizes the entities listed in C to disclose protected health information that is relevant to:

1. The member of the body that was injured as indicated on the claim application form. (see box 33)
2. The description of how the accidental injury occurred as indicated on the claim application form. (see box 31)
3. The description of how the occupational disease occurred as indicated on the claim application form. (see box 32)

The protected health information that may be disclosed includes, but is not limited to: history, findings, office and patient charts, files, examination and progress notes, and physical evidence.

F. I understand that I may revoke this authorization by giving written notice to all parties to my claim for workers' compensation, except to the extent that this authorization has already been acted on prior to receipt of my revocation.

I understand that the information disclosed by this authorization may be subject to redisclosure by the recipient to a medical manager, health care professional or registered rehabilitation practitioner, and others consistent with state and federal law.

By signing this form, I am authorizing the disclosure of my protected health information. This authorization is valid for one year from the date the claim is filed.

_____ _____

Patient/Claimant Signature Date

A photocopy, facsimile or electronic transmission of this signed authorization form is valid.