Division 08 Health and Safety

Chapter 16 – Reporting Injuries on the Job

March 2009

POLICY

This General Order shall define mandatory steps that all Prince George's County Fire/Emergency Medical Services (EMS) Department employees and volunteer members must take following an injury on the job.

DEFINITIONS

Compensable Accidental Injuries – Compensable accidental injuries are injuries that have arisen "out of and in the course of employment." **Not all work place injuries are compensable**.

Compensable Occupational Diseases – Compensable occupational diseases are ailments resulting from work conditions inherent and inseparable from employment.

Risk Manager – The Risk Manager, as designated by the Fire Chief, shall be the Manager of the Risk Management Office (RMO). The Risk Manager may designate a Risk Management Coordinator to assist in carrying out delegated responsibilities.

PROCEDURES

1. Reporting

Career/Civilian/Volunteer Injury Claims

Employee/member shall notify his/her supervisor immediately of accidental injury or within 24 hours of when the employee knew or should have known of the existence of an occupational disease.

If the supervisor is unavailable, employee/member shall notify the Fire/EMS Operations Center who will notify the Departmental Duty Officer.

Employee/member shall make proper entry in duty station/office log book, including name, ID number, date, time, and nature of injury.

If medical treatment is sought, the employee/member shall alert physicians, hospitals, and clinics of the following information:

- That the injured person is a County employee or volunteer member.
- That the case is a Workers' Compensation claim.
- That all bills, medical reports, and inquiries related to the injury are to be forwarded to: Prince George's County Fire/EMS Department, Risk Management Office, Fire Services Building, Room 120, 6820 Webster Street, Landover Hills, Maryland 20784
- That the physician completes and signs the Attending Physician's Statement and submits to the RMO the next business day. These forms must be updated and submitted to the RMO a minimum of every 30 days. However, more frequent reporting may be required.
- All Departmental burn injuries, regardless of the degree of injury, shall be assessed in the Burn Center at Washington Hospital Center (BCWHC). Acute burn injuries can be received at MedStar then triaged to

the Burn Unit or the Burn Clinic, as indicated. Release to full duty from burn injuries will only be approved by the Fire Department from the authorized representatives of the Burn Clinic.

All injury on-the-job notifications require the submission of the forms indicated below. Volunteer members shall additionally complete and sign the form in 6.d. with their employer's information. A Fire Fighter Casualty Report and EMAIS report shall also be completed and forwarded to Information Management within 72 hours of the incident. These forms are available on the share drive.

To file an injury claim, the following forms must be completed and signed by the immediate supervisor, and submitted to the RMO via chain-of-command, even if medical treatment is not sought at the time of injury:

- Appropriate Workers' Compensation Employer's First Report of Injury or Illness, Acord 4 (Attachment #1a or #1b). The employee/member's current home address and telephone number must be on the form.
- Supervisor's Accident Investigation and Report for Personal Injury, PGC Form 1384 (Attachment #2).
- Supervisor's Follow-up and Return to Work Notice, PGC Form 1383 (Attachment #3).
- Provident First Notice of Claim (Attachment #7).
- Fire Fighter Casualty Report

Injury claims will be reviewed by RMO for completeness and accuracy and forwarded to the appropriate agencies in accordance with Prince George's County Fire/EMS Department rules and regulations.

2. Recurrence of Previously Reported Injury

Any recurrence of a previously reported and properly documented injury or illness will require the completion and submission of all forms indicated for a new injury, with the exception of the Acord 4 form.

All supervisor responsibilities remain unchanged; however, an additional Acord 4 form is not required.

"Recurrence" should be written in the upper right hand corner of each form of the recurrence package. The new paperwork should indicate the reason for the recurrence.

3. Reimbursement for Prescriptions

Receipts for prescriptions issued by the physician for an injury or illness may be forwarded to RMO with a statement that includes the date of injury, physician's name, and the name of the medicine. Employee/member needing long-term maintenance prescriptions filled may contact the RMO or the Department's program administrator for assistance.

4. Hospitalization

Career employees and volunteer members of the Prince George's County Fire/EMS Department shall immediately notify, or arrange for notification to, Public Safety Communications (PSC) and/or Fire/EMS Operations Center of entry and/or discharge from the hospital when such hospitalization is the result of a job-related injury or illness. This information will be made available to the Office of the Fire Chief, the Departmental Duty Officer, and the Fire/EMS Department Chaplain.

5. Career and Civilian Light Duty

Personnel shall report to the RMO for a light-duty assignment when released by their physician or by order of the Fire Chief (or designee).

Personnel must bring a completed Attending Physician's Statement Temporary Disability Form with them when reporting to the RMO.

Personnel detailed to a light-duty assignment will be informed as to whom their new supervisor will be. That supervisor will be responsible for the employee's administrative functions, i.e. verifying light-duty hours on the time sheet, leave used, and forwarding timesheet to the RMO for final verification, etc.

Personnel will remain on light duty until they are released by their treating physician or ordered back to full duty by the Fire Chief (or designee). The employee will report to the RMO with the completed Attending Physician's Statement Temporary Disability Form indicating the employee has been released to full duty.

The RMO will make all assignments of career and civilian personnel to light-duty positions. Light-duty assignments will be based upon:

- The needs of the Fire/EMS Department.
- The medical information provided by the treating/examining physician, medical records, and/or the Medical Advisory Board.
- The particular talents, qualifications, and rank of the light-duty employee.

Commands and offices within the Fire/EMS Department will notify the RMO of their needs/requests for light-duty personnel. Requests shall be made on the appropriate "Request for Light-Duty Personnel" form (Attachment #8) and a file will be maintained in the RMO of current requests.

Personnel will remain on light duty until they are released by their physician or ordered back to full duty by the Fire Chief (or designee). The employee will report to the RMO with the completed Attending Physician's Statement Temporary Disability Form, indicating the physician has released the employee to full duty.

6. Volunteer Light Duty

This applies to all volunteer members who have been injured on-the-job and have been assigned to light duty by a treating or examining physician. Volunteer light-duty members will remain assigned to their respective stations. Members' duties will be limited to administrative functions only involving non-emergency operational activities.

Members will remain on light duty until released by their physician and they have physically reported to the RMO with their completed Attending Physician's Statement/Temporary Disability Form releasing them back to full duty. Members will then notify their volunteer chief they are back on full duty.

7. Reporting Disability Leave/Light Duty Hours on Timesheets

All timesheets with disability leave and/or light duty hours are to be submitted to the RMO for verification.

All disability leave reported on time sheets must have appropriate medical documentation submitted to verify hours. The original forms must be submitted to the RMO. For example, if an employee is on light duty, but uses disability leave to see a physician for -up care, an Attending Physician's

Statement/Temporary Disability Form must be submitted to verify these hours. All employees on disability leave will be temporarily re-assigned to the RMO. All disability leave timesheets will be maintained by the RMO and must be approved by the Risk Manager or designee.

A maximum of four hours/day of disability leave will be allowed for a physician/medical specialist office visit or follow-up appointment unless written verification is received from the physician/medical specialist indicating the medical need for more time. This provision is for treating doctor's visit only as per current Labor Agreement or Personnel Law.

An employee who does not have the proper medical verification for disability leave or is not in compliance with their current Medical Advisory Board/Disability Review Board ruling may be subject to the provisions of Personnel Law Section 16-226, Absence without leave. Conversion to other leave may be approved by the Fire Chief upon presentation of acceptable proof by the employee that the unauthorized absence of the employee was due to extenuating circumstances beyond the employee's control. This request must be in writing to the Fire Chief within two weeks of the acceptable proof.

The need for disability leave may be reviewed by the Department's Medical Review Officer and voted on by the Disability Review Board.

8. Responsibilities

Career/Civilian Employee

Each career/civilian employee of the Department should review these procedures. It is the individual employee's responsibility to ensure the completion and submission of all appropriate forms in a timely manner. The original Attending Physician's Statement and the Temporary Disability Form must be submitted to the RMO.

When totally or partially incapacitated and unable to perform regular work for more than three days, a claim for compensation must be made on the Employee's Claim – Worker's Compensation Commission, WCC Form C1 (Rev 3/98) (Attachment #6). Form C1 must be fully completed and mailed promptly to the Workers' Compensation Commission at the address on the top of the form. It is the employee's responsibility to submit this form.

All employees must cooperate in the investigation of the circumstances causing the injury or illness.

Employees will be placed on the appropriate leave status based upon the employee's current labor agreement or Personnel Law.

Employees on disability leave who have a part-time job must report the name and address of the business, work days and hours, and current supervisor. A memorandum with this information must be sent, through the chain-of-command, to the RMO upon being placed on disability leave. An employee on disability leave cannot work a part-time job without forfeiting their disability benefits.

Employees on disability leave are not expected to leave their residence during normal work hours without first obtaining approval by the Fire Chief (or designee), except for necessary medical services, legal hearing regarding the disability, or in the event of a family emergency. Failure to follow proper procedures may result in the employee being placed in the disciplinary process and having to use annual leave,

and/or jeopardize the employee's disability leave status.

Career/Civilian Supervisors

Career/civilian supervisors shall:

- Ensure that their employees understand their role in the IOJ process.
- Ensure the completion of the appropriate forms and sign the Acord 4 in "Preparer's Name & Title" block.
- Complete the Supervisor's Follow-up and Return to Work Notice, PGC Form 1383 (Attachment #3).
- Submit additional narratives as necessary for further clarification of information pertinent to the injury or illness.
- Forward all forms, via chain-of-command, to the RMO by 0900 hours the next workday.
- All work status changes to light or full duty must be reported to the RMO.

Battalion Chiefs

Battalion Chiefs shall:

- Ensure that employees and career supervisors understand their role in the IOJ process.
- Review all claim forms for legibility and accuracy.
- Complete and sign the "Sub-Activity Review and Appraisal" section of the Supervisor's Accident Investigation & Report for Personal Injury form.
- Forward all forms to the RMO by 0900 hours the next workday.

Majors/Managers

Majors/Managers shall ensure compliance within their area of responsibility.

Risk Manager

The Risk Manager, or designee, shall be responsible for:

- Review, accuracy, and timely submission of all IOJ reports to the appropriate agencies in accordance with the Department's rules and regulations.
- Ensuring all disability time reported on time sheets has a current Attending Physician's Statement and Temporary Disability Form submitted to verify hours requested.
- Posting the OSHA Form 300A, Summary of Work Related Injuries and Illnesses for the Prince George's County Fire/Emergency Medical Services (EMS) Department, in accordance with OSHA requirements.

The RMO may forward the request for disability leave to a County-authorized physician for an Independent Medical Evaluation (IME). Cases will also be subject to review by the County Medical Advisory Board. Personnel who are on disability leave for more than one week may be subject to a medical examination. A County-authorized physician will do the medical examination. Medical examination results will be forwarded to the County Medical Advisory Board (MAB) for determination of continued disability leave, full duty, light-duty status, or retirement.

Volunteer Members

Each volunteer member of the Department should review these procedures. It is the individual member's responsibility to ensure the completion and submission of all appropriate forms in a timely manner. The original Attending Physician's Statement and

the Temporary Disability Form must be submitted to the RMO.

When totally or partially incapacitated and unable to perform regular work for more than three days, a claim for compensation must be made on the Employee's Claim Form, Workers' Compensation Commission, WCC, Form C1, (Rev. 3/98) (Attachment #6). The member is responsible to submit this form. Form C1 must be fully completed and mailed promptly to Workers' Compensation Commission at the address at the top of the form.

All members must cooperate in the investigation of the circumstances causing the injury or illness.

All volunteer members receiving temporary total disability benefits who have a full or part-time job must report the name and address of the business, work days and hours, and current supervisor. Members on disability leave would not be expected to be working full or part-time. A memorandum must be sent, through the chain-of-command, to the Fire Chief, or designee, within one week of receiving temporary total disability benefits.

Volunteer Supervisors

Volunteer supervisors shall:

- Ensure that their members understand their role in the IOJ process.
- Ensure the completion of the appropriate forms and sign the Acord 4 in "Preparer's Name & Title" block.
- Complete the Supervisor's Accident Investigation & Report for Personal Injury, PGC Form 1384.
- Complete the Supervisor's Follow-up and Return to Work Notice, PGC Form 1383.
- Complete the Provident First Notice of Claim.
- Complete additional narratives as necessary for further clarification of information pertinent to the injury or illness.
- Forward all forms, via chain-of-command, to the RMO by 0900 hours the next workday.

Volunteer Chief and/or President

The Volunteer Chief and/or President shall:

- Ensure that all members understand their role in the IOJ process.
- Review all claim forms for legibility and accuracy.
- Complete and sign the "Sub-Activity Review and Appraisal" section of the Supervisor's Accident Investigation & Report for Personal Injury form.
- Ensure all forms are forwarded to the RMO by 0900 hours the next workday.

9. Claim Distribution

Career/Civilian Employees

One copy of each claim package will be kept in the RMO. The original claim package will be forwarded to the appropriate Workers' Compensation carrier.

The RMO will complete the Disability Leave Form, PGC Form 2099, for all career employees upon release to full or light duty status. Copies will be distributed to the appropriate claims service contractor, the Office of Personnel and Labor Relations, Pensions Division, and the career employee's file.

The Office of Personnel and Labor Relations, Pensions Division, completes and distributes

the Disability Leave Form, PGC 2099, for all civilian employees.

Volunteer Members

One copy of each claim package is kept in the RMO. The original claim will be forwarded to the appropriate Workers' Comp carrier.

Volunteer member and his/her supervisor must complete the Provident First Notice of Claim form. (Attachment #7)

10. Compliance

Failure to follow this General Order may result in the denial of a claim. It is unlawful for any employee or member to make a false statement in connection with any of the matters covered by this General Order. If an employee or member makes a false statement in connection with any of the enumerated provisions, the employee or member shall be subject to disciplinary action up to and including immediate dismissal. A false statement in connection with any of the matters covered by this General Order shall amount to the falsification of County reports or documents under Section 16-193(c)(1)(A)(iv) of the Prince George's County Code.

REFERENCES

N/A

FORMS/ATTACHMENTS

Attachments 1a and 1b - Appropriate Workers' Compensation Employer's First Report of Injury or Illness

Attachment #2 - Supervisor's Accident Investigation and Report for Personal Injury, PGC Form 1384

Attachment #3 - Complete the Supervisor's Follow-up and Return to Work Notice, PGC Form 1383

Attachment #4 - Attending Physician's Statement/Temporary Disability Form

Attachment #5 – Employee/Member's Statement of Injury or Illness

Attachment #6- Employee's Claim Form, Workers' Compensation Commission, WCC, Form C1, (Rev. 7/07)

Attachment #7- Provident First Notice of Claim

Attachment #8 - Request for Light-Duty Personnel

WORKER'S COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

OSHA CASE/FILE#

GENERAL

EMPLOYER (NAME & ADDRESS INCL ZIP)
Prince George's County Volunteer Fire Dept.
6820 Webster Street
Landover Hills, MD 20784

CARRIER/ADMINISTRATOR CLAIM NUMBER

JURISDICTION

JURISDICTION CLAIM NUMBER

DO NOT WRITE IN SPACE BELOW

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)

LOCATION #

SIC CODE
N/A

UNEMPLOY
FED TAX I.D. NO.: 52-6000998

PHONE #
301-583-1951

CARRIER / CLAIMS ADMIN

CARRIER (NAME, ADRRESS & PHONE NO)

American International Group, Inc.
1700 Market Street
Philadelphia, PA 19103
(215) 255-6307

POLICY PERIOD

CHECK IF APPROPRIATE

X STATE FUND

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

Prince George's County Fire/EMS Dept.
6820 Webster Street, Rm 120
Landover Hills, MD 20784

CARRIER FIEN

POLICY/SELF-INSURED NUMBER
9844525

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE

NAME (Last, First, Middle)

DATE OF BIRTH

SOCIAL SECURITY NUMBER

DATE HIRED

STATE OF HIRE

ADDRESS (INCL ZIP)

SEX
MALE
FEMALE
UNKNOWN

MARITAL STATUS
UNMARRIED SINGLE/DIVORCED
MARRIED
SEPARATED
UNKNOWN

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

TELEPHONE (INCLUDE AREA CODE)

OF DEPENDENTS

NCCI CLASS CODE

REGULAR DEPT. OR DIVISION

Occupation
Volunteer Firefighter

WAGE

WAGE INFORMATION FOR REGULAR EMPLOYER

$ PER:

HOUR

Week

MONTH

DAYS WORKED/WEEK

OTHER:
AVERAGE WAGE/WEEK AT TIME OF INJURY $

FULL PAY FOR DAY OF INJURY? YES NO

DID SALARY CONTINUE? YES NO

OCCURRENCE

TIME EMPLOYEE BEGAN WORK AM PM

DATE OF INJURY/ILLNESS

TIME OF OCCURRENCE AM PM

DATE EMPLOYER NOTIFIED

INDIVIDUAL NOTIFIED

CONTACT NAME/PHONE NUMBER

DATE RETURNED TO WORK

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? YES NO

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

OCCURRENCE

PLACE OF ACCIDENT OR OCCURRENCE (INCL. State)

DESCRIBE NATURE OF INJURY OR ILLNESS IN DETAIL (Include part of body affected, eg. amputation of right index finger at 2nd joint, fractured arm, lead poisoning)

DESCRIBE EMPLOYEE'S ACTIVITIES WHEN INJURY OCCURRED WITH DETAILS OF HOW EVENT OCCURRED (Include name of other individuals involved, tools, machinery, objects, vapors, chemicals, radiators, unnatural motions of employee)

DATE RETURN(ED) TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? N/A YES NO

WERE THEY USED? N/A YES NO

TREATMENT

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT (CHECK ONE)

- NO MEDICAL TREATMENT
- MINOR: BY EMPLOYER
- MINOR CLINIC/HOSP
- EMERGENCY CARE
- HOSPITALIZED > 24 HRS
- FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESS TO INJURY (NAME & PHONE #)

DATE MAILED TO INSURER

DATE PREPARED

PREPARER'S NAME & TITLE

PHONE NUMBER

NOTICE

This form is NOT a claim for compensation. Failure to file a claim within 2 years of the date of accidental injury may bar an employee's claim for compensation. Employees may obtain claim forms from the Workers' Compensation Commission.

EMPLOYER:
COMPLETE BOTH SIDES OF THIS FORM AND SEND IT IMMEDIATELY TO –

WORKERS' COMPENSATION COMMISSION
6 NORTH LIBERTY STREET, BALTIMORE, MARYLAND 21201-3785

A copy of this form must be mailed to the DIVISION OF LABOR AND INDUSTRY, 1100 N. EUTAW STREET, SUITE 611, BALTIMORE, MARYLAND 21201 and an additional copy should be sent by the employer to his or her workers' compensation insurance carrier. The weekly earnings schedule below of the employee whose injury is being reported on the front side of this form should be completed at the time the report is submitted if at all possible, but in any event the wage information must be supplied no later than ten (10) days following the employer's receipt of a Notice of Claim form the Commission. An employer's failure to submit the wage information as required will result in the Commission's use of information supplied by the Claimant to the possible detriment of the employer.

REPORT OF WAGE INFROMATION

Injured Employee Name _____ Social Security Number _____

Week No.	*Month*	*Week Ending Day*	*Year*	*Days Worked*	GROSS *Amount Paid Including all Overtime*
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					

Was this employee given free rent, lodging, board, tips or other allowances in addition to the above earnings? If yes, state weekly value thereof. $ _____

Signed _____

WORKER'S COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

OSHA CASE/FILE#

GENERAL

EMPLOYER (NAME & ADDRESS INCL ZIP)
County Executive and County Council
For Prince George's County
Room 3200, County Admin. Bldg.
14741 Governor Oden Bowie Drive
Upper Marlboro, Maryland 20772

SIC CODE: N/A

UNEMPLOY FED TAX I.D. NO.: 52-6000998

CARRIER/ADMINISTRATOR CLAIM NUMBER

JURISDICTION

JURISDICTION CLAIM NUMBER

DO NOT WRITE IN SPACE BELOW

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)

LOCATION #

PHONE #

CARRIER / CLAIMS ADMIN

CARRIER (NAME, ADRRESS & PHONE NO)
CorVel Corporation
9475 Lottsford Road #220
Landover, MD 20785
(301) 925-4024

POLICY PERIOD
07/01/65
TO
Present

CHECK IF APPROPRIATE
X SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
Prince George's County Fire/EMS Dept.
6820 Webster Street, Rm 120
Landover Hills, MD 20784

CARRIER FIEN

POLICY/SELF-INSURED NUMBER
S-1810

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

NAME (LAST, FIRST, MIDDLE)

DATE OF BIRTH

SOCIAL SECURITY NUMBER

DATE HIRED STATE OF HIRE

ADDRESS (INCL ZIP)

SEX
MALE
FEMALE
UNKNOWN

MARITAL STATUS
UNMARRIED SINGLE/DIVORCED
MARRIED
SEPARATED
UNKNOWN

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS
Full Time

TELEPHONE (INCLUDE AREA CODE)

OF DEPENDENTS

NCCI CLASS CODE

WAGE

RATE PER: HOUR / Week MONTH

OTHER:
AVERAGE WAGE/WEEK AT TIME OF INJURY $

DAYS WORKED/WEEK

FULL PAY FOR DAY OF INJURY? X YES NO

DID SALARY CONTINUE? X YES NO

OCCURRENCE

TIME EMPLOYEE BEGAN WORK AM / PM

DATE OF INJURY/ILLNESS

TIME OF OCCURRENCE X AM / PM

LAST WORK DATE

DATE EMPLOYER NOTIFIED

INDIVIDUAL NOTIFIED

CONTACT NAME/PHONE NUMBER

TYPE OF INJURY/ILLNESS

PART OF BODY AFFECTED

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? YES NO

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

PLACE OF ACCIDENT OR OCCURRENCE (Incl. State)

DESCRIBE NATURE OF INJURY OR ILLNESS IN DETAIL (Include part of body affected, eg., amputation of right index finger at 2nd joint, fractured arm, lead poisoning)

DESCRIBE EMPLOYEE'S ACTIVITIES WHEN INJURY OCCURRED WITH DETAILS OF HOW EVENT OCCURRED (include name of other individuals involved, tools, machinery, objects, vapors, chemicals, radiations, unnatural motions of employee)

DATE RETURN(ED) TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? N/A X YES NO

WERE THEY USED? N/A X YES NO

TREATMENT

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT (CHECK ONE)

- NO MEDICAL TREATMENT
- MINOR: BY EMPLOYER
- MINOR CLINIC/HOSP
- EMERGENCY CARE
- HOSPITALIZED > 24 HRS
- FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESS TO INJURY (NAME & PHONE #)

DATE MAILED TO INSURER

DATE PREPARED

PREPARER'S NAME & TITLE

PHONE NUMBER

NOTICE

This form is NOT a claim for compensation. Failure to file a claim within 2 years of the date of accidental injury may bar an employee's claim for compensation. Employees may obtain claim forms from the Workers' Compensation Commission.

EMPLOYER:
COMPLETE BOTH SIDES OF THIS FORM AND SEND IT IMMEDIATELY TO –

WORKERS' COMPENSATION COMMISSION
6 NORTH LIBERTY STREET, BALTIMORE, MARYLAND 21201-3785

A copy of this form must be mailed to the DIVISION OF LABOR AND INDUSTRY, 1100 N. EUTAW STREET, SUITE 611, BALTIMORE, MARYLAND 21201 and an additional copy should be sent by the employer to his or her workers' compensation insurance carrier. The weekly earnings schedule below of the employee whose injury is being reported on the front side of this form should be completed at the time the report is submitted if at all possible, but in any event the wage information must be supplied no later than ten (10) days following the employer's receipt of a Notice of Claim form the Commission. An employer's failure to submit the wage information as required will result in the Commission's use of information supplied by the Claimant to the possible detriment of the employer.

REPORT OF WAGE INFROMATION

Injured Employee Name _____ Social Security Number _____

Week No.	*Month*	*Week Ending Day*	*Year*	*Days Worked*	GROSS	*Amount Paid Including all Overtime*
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						

Was this employee given free rent, lodging, board, tips or other allowances in addition to the above earnings? If yes, state weekly value thereof. $ _____

Signed _____

(MD Supp Rev 12/97)

PRINCE GEORGE'S COUNTY

SUPERVISOR'S INCIDENT INVESTIGATION & REPORT FOR PERSONAL INJURY

EMPLOYEE _____ SOCIAL SECURITY NO. _____
OCCUPATION _____ EMPLOYMENT (IN YEARS) _____ AGE _____
ORGANIZATION _____ SUB-ACTIVITY _____ FUNCTIONAL AREA _____
DATE OF ACCIDENT _____ TIME _____ POLICE ONLY: ☐ ON DUTY ☐ OFF DUTY

LOCATION OF ACCIDENT _____

INCIDENT DESCRIPTION _____

INJURY DESCRIPTION _____

WHY DID THIS INCIDENT OCCUR? _____

HAZARD PRESENT (SPECIFY) _____

CONTRIBUTING FACTORS _____

WERE ESTABLISHED SAFETY STANDARDS FOR THIS TASK ENFORCED BY THE SUPERVISOR?
USED? YES ☐ NO ☐ EXPLAIN:

IDENTIFY THREE EDUCATIONAL/CORRECTIVE ACTIONS THAT YOU WILL TAKE WITH YOUR CREW WITHIN 10 DAYS TO PREVENT THIS TYPE OF INCIDENT IN THE FUTURE?
1.
2.
3.

CORRECTIVE ACTION TAKEN? - DATE _____

PERSONAL PROTECTIVE EQUIPMENT REQUIRED (SPECIFY TYPE) _____

USED? YES ☐ NO ☐

MEDICAL TREATMENT (WHERE?) _____

DID INJURY RESULT IN EMPLOYEE'S DISABILITY? _____

HAS EMPLOYEE RETURNED TO WORK? (IF YES, DATE & TIME) _____

DATE & TIME INCIDENT REPORTED BY EMPLOYEE _____

DATE OF INVESTIGATION _____

SIGNED (SUPERVISOR OR INVESTIGATOR _____

PGC #1384 Rev 02/08

SUB-ACTIVITY REVIEW AND APPRAISAL

1. IN YOUR OPINION, WHAT WAS THE IMMEDIATE CAUSE OF THIS ACCIDENT?

____

2. IN YOUR OPINION, WHAT WERE THE CONTRIBUTING FACTORS? ______________

____

3. WHAT ARE YOUR RECOMMENDATIONS? ______________________

____

____

4. HAVE THEY BEEN IMPLEMENTED? ☐ ____ YES ☐ ______ NO
   IF 'NO' EXPLAIN: ______________________________

SIGNED ______________________ DATE ______________
(Sub-Activity Reviewing Authority)

_ _

ORGANIZATION REVIEW AND ASSIGNMENT OF CODES

1. **ORGANIZATION/SUB-ACTIVITY/FUNCTIONAL AREA** ______________
2. **AGE** ______________
3. **OCCUPATION** ______________
4. **EXPERIENCE** ______________
5. **TYPE OF ACCIDENT** ______________
6. **CLASS OF INJURY** ______________
7. **NATURE OF INJURY** ______________
8. **PART OF BODY** ______________
9. **SOURCE OF INJURY** ______________
10. **HAZARD** ______________
11. **UNSAFE ACT** ______________
12. **CONTRIBUTING FACTOR** ______________
13. **ESTIMATED TIME LOST** ______________
14. **ACCIDENT LOCATION (POLICE AND FIRE)** ______________
15. **PERSONAL PROTECTIVE EQUIPMENT (PUBLIC WORKS)** ______________

SIGNED ______________________ DATE ______________
(Organization Review Authority)

_ _
FOR SAFETY OFFICE USE ONLY

CASE NUMBER __________ MOSHA LOG ENTRY? __________ YES __________ NO
OCCUPATIONAL INJURY __________ OCCUPATIONAL ILLNES __________

PRINCE GEORGE'S COUNTY

SUPERVISOR'S FOLLOW-UP AND RETURN TO WORK NOTICE

EMPLOYEE _____

SOCIAL SECURITY NUMBER _____

ORGANIZATION _____ SUB-ACTIVITY _____ FUNCTIONAL AREA _____

DATE OF ACCIDENT _____ DATE OF REOCCURRENCE _____

SUPERVISOR'S FOLLOW-UP (Sign and date below)

HAD EMPLOYEE BEEN CONTACTED SINCE THE INJURY? _____ YES _____ NO

DATE EMPLOYEE WAS CONTACTED _____

HOW WAS EMPLOYEE CONTACTED? _____

EMPLOYEE'S STATUS (INCLUDE CURRENT CONDITION AND ANTICIPATED DATE OF RETURN TO WORK)

_____

_____

RETURN TO WORK NOTICE

DATE RETURNED TO WORK _____

HAS EMPLOYEE BEEN REASSIGNED AS A RESULT OF INJURY? YES ___ NO ___

NUMBER OF WORK DAYS LOST DUE TO INITIAL INJURY _____

NUMBER OF WORK DAYS LOST DUE TO REOCCURRENCE _____

NUMBER OF DAYS ON LIGHT DUTY _____

WORK RESTRICTIONS _____

_____

_____

SUPERVISOR _____ DATE _____

REVIEWING AUTHORITY _____ DATE _____

_ __

FOR SAFETY OFFICE USE ONLY

CASE NUMBER _____ MOSHA LOG ENTRY? _____ YES _____ NO

TOTAL WORK DAYS LOST _____

P.G.C. FORM #1383 (Rev. 6/78)

Prince George's County Fire/EMS Department

Attending Physician's Statement/Temporary Disability Form

-Report to be completed by employee/member and the employee/member's treating physician-

TO BE COMPLETED BY THE EMPLOYEE/MEMBER

Recurrence: ☐Yes ☐No

Date of Injury: _____

Employee/Member: _____ **FD ID #:** _____

Description of event causing injury: _____

Employment Status: ☐Career ☐Civilian ☐Volunteer **Job Description:** ☐FF/EMT ☐ FF/PM ☐ PM ☐Admin ☐Other

Normal Work Hours: ☐Shift work, up to 24 hours ☐Day work, up to 10 hours ☐Volunteer work, averaging a/an ___hour shift

Position Description: The employee/member shall check all that apply.

☐ **Firefighter:** Firefighters are responsible for performing firefighting and rescue operations that expose them to extreme heat, toxic products of combustion, and hazardous materials. They may be required to: carry a forcible entry bag (weighing 26 lbs) and climb 46 steps, return to ground and carry another entry bag and climb 31 steps; remove a 14' roof ladder from hangers and carry ladder 75 feet without ladder touching ground; drag a person weighing approximately 150 lbs for 75 feet; as well as drive fire apparatus under emergency conditions. Studies have shown that firefighters may achieve heart rates of 85 to 100% of their maximum capacity, and that this level may be sustained for long periods of time.

☐ **EMT or Paramedic:** EMTs or paramedics are required to respond utilizing lights and sirens to the scene of various types of medical emergencies as well as hazards such as fires and chemical spills. As a result, they may be exposed to infectious diseases, toxic products of combustion, hazardous vapors and temperature extremes for long periods of time. Their job entails that they be part of a two-person team that regularly lifts an average 150 lb patient and additional equipment weighing approximately 50 lbs up and down stairwells and into and out of ambulances. They are required to communicate both orally and in writing to hospitals, their supervisors, and the public.

☐ **Career Employee:** Career employees assigned to Full Duty are required to participate in physical training as a part of the employee's job description. The Department conducts annual fitness performance appraisals for employees that incorporate an 85% sub-maximal graded treadmill test, maximum push-ups, maximum sit-ups, flexibility, maximal grip strength, and body mass index. All career employees are required to maintain an aerobic capacity of 42 ml/kg/min measured during Departmental medical physicals. Physical fitness training regimens may vary due to individual medical conditions but all employees who fail to obtain the prescribed aerobic capacity will not be allowed on Full Duty until the Medical Advisory Board makes a determination.

☐ **Civilian Employee:** Assigned duties vary by position. The employee should provide a job description to the physician for review. Please contact the Prince George's County Fire/EMS Department, Risk Management office at 301-583-1951 for additional information.

TO BE COMPLETED BY PHYSICIAN – Medical Condition

Date of Medical Appointment: _____

Is the injury or illness related to the patient's involvement with the PGC Fire/EMS Department? ☐Yes ☐No ☐ Unknown

Diagnosis (Primary diagnosis and secondary conditions, including any complications)**:** _____

_____

_____

_____

_____

Treatment Plan: _____

_____

_____

_____

TO BE COMPLETED BY PHYSICIAN continued – Work Status

Work Status: Check the appropriate work status block and complete any additional information requested based on the employee/member's medical diagnosis, treatment plan and capacity to work. An employee can only be placed on disability leave or light duty from the Fire/EMS Department upon receipt of this completed, signed and dated form.

The Fire/EMS Department Physician and/or Medical Advisory Board may review your medical evaluations, objective findings and work status determination. They may require additional medical information, department physical, or an independent medical evaluation prior to authorizing an employee to return to work. They may also approve, deny, or change the employee's work status.

☐ **FULL DUTY**: All assigned activities as applicable and listed in the position description(s), regardless of present work assignment, may be performed as well as any applicable physical training requirements. Physical training requirements may be altered, but prescribed aerobic capacity must be met in order to qualify for full duty.

Date released to full duty: _____ Alterations in physical training requirement: _____

☐ **LIGHT DUTY**: No assigned activities as applicable and listed in the position description may be performed and the employee/member may not continue in a full duty assignment. A light duty assignment normally is an 8-hour/day work assignment. The Department can accommodate most work restrictions and limitations with modified/alternative work assignments and hours. If the patient demonstrates a limited loss of function, please provide restrictions and limitations and the date they began below.

Restrictions (what the patient should not do): _____

_____

Limitations (What the patient cannot do): _____

_____

☐ Date released to full duty: _____ - or - ☐ Date of next appointment/evaluation (30 day max): _____

☐ **NO DUTY**: Employees/members shall be considered on light duty unless there is total incapacity and inability to perform any assigned work. This employee/member is temporarily and totally incapacitated and unable to perform any assigned work. The employee is required to remain at home recuperating except for medical visits, legal visits related to the injury and/or family emergencies. The medical reason for the employee/member's total incapacitation and inability to work light duty with listed restrictions or limitations is: _____

_____

_____

If you would like the employee/member to continue in some type of physical training or therapy, please list types of activities they may engage in: _____

☐Date released to ☐full duty or ☐light duty _____ - or - ☐ Date of next appointment/evaluation (30 day max): _____

REQUIRED ATTACHMENTS AND SIGNATURES

Please make sure that office notes, test results, and discharge summaries are attached or provided to the Prince George's County third party claims administrator. This will help reduce additional requests.

FRAUD NOTICE: Any person who knowingly files a false statement of claim containing false or misleading information is subject to criminal penalties, civil penalties, and for employees/members, disciplinary action up to and including dismissal. This includes Employee and Attending Physician portions of this form.

Name of Physician (print)_____ Degree: _____ Medical Specialty: _____

Street Address: _____ Phone #: _____

City: _____ State: _____ Zip Code: _____ Fax #: _____

Signature of Physician: _____ Date: _____

*Note: If you have any questions regarding this form, the individual's job description(s), etc. please contact the Prince George's County Fire/EMS Department, Risk Management office at 301-583-1951.

Prince George's County Fire/EMS Department
Employee/Member's Statement of Injury or Illness

Recurrence: ☐ Yes ☐ No

Date of Initial Injury:

GENERAL INFORMATION

FD ID #: Rank:

Employee/Member Name: ,

Date of Injury: Supervisor and/or Ops Center notified: ☐ Yes ☐ No Logbook entry made: ☐ Yes ☐ No

Do you have part time employment: ☐ Yes ☐ No (Yes requires business name, address, work hours and supervisor information be sent to Risk Management)

NOTE: If this is an occupational exposure, follow reporting procedures outlined in General Orders 5-16, 5-17, or 5-19

INJURY INFORMATION

Description of injury:
(Medical condition, body part, etc.)

Why did this incident occur?
(Give brief description as to why you feel this incident occurred?)

Were you authorized by supervisor and/or employer to engage in activity resulting in injury: ☐ Yes ☐ No

What would have prevented this incident from occurring?
(Give brief description of what you feel would have prevented this incident from occurring?)

Supervisor at time of injury: , Supervisor's rank:

Description of event causing injury:
(Who, what, when, where, why, and how….)

Other contributing factors to injury: ☐ Yes ☐ No If yes, explain:

Were safety hazards present that contributed to injury: ☐ Yes ☐ No If yes, explain:

Were you following Department rules and regulations at time of injury: ☐ Yes ☐ No If no, explain:

Was Personal Protective Equipment (PPE) required to be worn during time of injury (see General Orders): ☐ Yes ☐ No

Was all PPE worn at time of injury: ☐ Yes ☐ No ☐ N/A Was PPE worn properly at time of injury: ☐ Yes ☐ No ☐ N/A

Was all PPE Department approved: ☐ Yes ☐ No ☐ N/A Was PPE clean at time of injury: ☐ Yes ☐ No ☐ N/A

Any PPE malfunctions: ☐ Yes ☐ No If yes, explain:

Other safety equipment available, i.e., needle safety container, seat belt, etc.: ☐ Yes ☐ No Type:

If available, was other safety equipment used: ☐ Yes ☐ No If no, explain:

Recommended corrective action, policy and/or rules and regulation changes to prevent future injuries:

Recommended safety equipment or equipment upgrades to prevent future injuries:

Additional Information:

REPORTING

Date Prepared: Preparer's Name: **Last Name**, **First Name MI**

FRAUD NOTICE: Any person who knowingly files a false statement of claim containing false or misleading information is subject to criminal penalties, civil penalties, and disciplinary action up to and including dismissal. This includes the MAIS report, the Employer's First Report of Injury or Illness, the Employee/Member's Statement of Injury or Illness form, the Attending Physician's Statement/Temporary Disability form and any other required or requested statement, report or form.

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.

CLAIM 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.

FIRST NOTICE OF CLAIM

PROVIDENT

Benefits for Emergency Service Organizations since 1928

PROVIDENT AGENCY, INC.
272 ALPHA DRIVE - P.O. BOX 11588
PITTSBURGH, PA 15238
TOLL-FREE: 800-447-0360
PHONE: 412-963-1200
FAX: 412-963-0415
www.providentbenefits.com

Name	Date of Birth / /	Social Security Number
Address		Home Phone Number ( )
What is your regular occupation?	Employed By (Name of Company)	
Employer's Address		Employer's Phone Number ( )
Please enclose pay stubs or prior year Schedule Cs (self employed).	Wages/Earnings Hourly: Weekly:	Date Last Worked / /
Time of Accident AM PM	Date of Accident / /	Place of Accident
What is your injury or illness?	How did it happen?	
Name and Address of Treating Physician	Name and Address of Hospital	
Did you lose any Time from Work? ❑ Yes ❑ No ❑ Unknown at this time	Did you file with Workers' Compensation? ❑ Yes ❑ No	
I was totally disabled from / / to / /	Date you have or are expected to return to work / /	

I CERTIFY THAT THE ABOVE ANSWERS ARE TRUE AND COMPLETE ACCORDING TO THE BEST OF MY KNOWLEDGE AND BELIEF.

I hereby authorize any physician, hospital, insurer, governmental agency, other organization or person having any records, data or other information concerning me to furnish such records, data or information as may be requested by Provident Life and Accident Insurance Company or its duly authorized representative. I understand that in executing this authorization I waive the right for such information to be privileged. A copy of this authorization shall be considered as effective and valid as the original.

Date _____ 20____ Signed _____
(Claimant)

THIS SECTION TO BE COMPLETED BY AUTHORIZED MEMBER OF FIRE DEPARTMENT, RESCUE OR AMBULANCE SQUAD

❑ Yes ❑ No – Claimant was a member of your organization at the time of injury or illness ❑ Yes ❑ No – Claimant was engaged in an authorized activity at the time of injury or illness		Policy Number
Name of Fire/Rescue/Ambulance Company/District or Relief Association		Your Municipality
Print Name and Title	Signed	Date / /
Address State Zip Code		Telephone Number ( )

A-31369 (2/02)

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

White Copy - Provident Yellow Copy - Workers' Compensation Pink Copy - Department or Company

Underwritten by Provident Life and Accident Insurance Company
1 Fountain Square. Chattanooga, TN 37402

0

INTER-OFFICE MEMORANDUM

PRINCE GEORGE'S COUNTY, MARYLAND

DATE _____

TO: Erroll W. George, Sr., Major
Risk Management Office

VIA: Chain-of-Command

FROM: _____
_____

RE: Request For Light-Duty Personnel

I am requesting _____ Light-Duty personnel for assisting me with a project. I understand using Light-Duty personnel will benefit the Department and the citizens of Prince George's County. The estimated duration of the project is _____ week(s). The individual(s) will normally work an 8-hour day assignment. The work may include but is not limited to the following activities: (please check the categories that the employee is <u>required</u> to perform)

_____Data entry into computer systems
_____Office duties
_____Operation of non-emergency vehicles
_____Lifting light equipment of less than 40 lbs.
_____Communication duties (e.g., phone/radio operations)
_____Building inspections (can include inspecting hazardous areas and climbing stairs)

Additional comments: _____

_____