

WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

G E N E R A L	EMPLOYER (NAME & ADDRESS INCL ZIP)			CARRIER/ ADMINISTRATOR CLAIM NUMBER			REPORT PURPOSE CODE			
	JURISDICTION			JURISDICTION CLAIM NUMBER						
	INSURED REPORT NUMBER									
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)						LOCATION #			
SIC CODE			EMPLOYER FEIN			PHONE #				
C L A I M S A D M I N I S T R A T O R	CARRIER (NAME, ADDRESS & PHONE NO)			POLICY PERIOD		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)				
				TO						
	CHECK IF APPROPRIATE									
	SELF INSURANCE									
CARRIER FEIN			POLICY/SELF-INSURED NUMBER			ADMINISTRATOR FEIN				
AGENT NAME & CODE NUMBER										
E M P L O Y E E	NAME (LAST, FIRST, MIDDLE)			DATE OF BIRTH		SOCIAL SECURITY NUMBER		DATE HIRED	STATE OF HIRE	
	ADDRESS (INCL ZIP)			SEX		MARITAL STATUS		OCCUPATION/JOB TITLE		
				M MALE		U UNMARRIED SINGLE/DIVORCED				
				F FEMALE		M MARRIED		EMPLOYMENT STATUS		
TELEPHONE (INCLUDE AREA CODE)			# OF DEFENDANTS		K UNKNOWN		NCCI CLASS CODE			
W A G E	RATE		PER:	DAY	MONTH	# DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY?		
			WEEK	OTHER:			DID SALARY CONTINUE?		YES	NO
O C C U R R E N C E	TIME EMPLOYEE		AM	DATE OF INJURY/ILLNESS		TIME OF OCCURRENCE		AM	LAST WORK DATE	
			PM					PM	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?				TYPE OF INJURY/ILLNESS CODE			PART OF BODY AFFECTED CODE		
DEPARTMENT OR LOCATION 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 THE 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?			YES	NO
									YES	NO
T R E A T M E N T O T H E R	PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)			HOSPITAL (NAME & ADDRESS)			INITIAL TREATMENT			
							0 NO MEDICAL TREATMENT			
							1 MINOR: BY EMPLOYER			
							2 MINOR CLINIC/HOSP			
						3 EMERGENCY CARE				
						4 HOSPITALIZED > 24 HRS				
						5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED				
WITNESS (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:** _____

Social Security Number: _____ **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					0.00
2					0.00
3					0.00
4					0.00
5					0.00
6					0.00
7					0.00
8					0.00
9					0.00
10					0.00
11					0.00
12					0.00
13					0.00
14					0.00
TOTALS		0	0.00	0.00	0.00

TOTAL 0.00 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)

- 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)