POLICIES AND PROCEDURES

MONTGOMERY COUNTY

DEPARTMENT OF FIRE AND RESCUE SERVICES

DATE March 7, 1991

TITLE WORKERS' COMPENSATION CLAIMS

DIRECTOR APPROVAL

PURPOSE

1.0 To establish guidelines for the completion and submission of Workers' Compensation claims for personnel of the Montgomery County Department of Fire and Rescue Services.

APPLICABILITY

2.0 All DFRS personnel.

DEFINITIONS

3.0 Claims Administrator - For primary insurance, an independent adjuster under contract to the Division of Risk Management, for the Montgomery County self-insurance program.

3.1 Accidental Injury - An accidental injury arising out of and in the course of employment as defined by the Workers' Compensation Statute and as interpreted by Maryland case law.

3.2 Insurance Administrator - For primary insurance coverage: Risk Management, a Division of Montgomery County Government, acting for Montgomery County Self Insurance Program.

3.3 Occupational Disease - An ailment, disorder, or illness which is the expectable result of working under conditions inherent in employment with the Department, which arises out of and in the course of employment, as defined by the Maryland Worker's Compensation statute and as interpreted by Maryland Case Law.

POLICY

4.0 It is the policy of DFRS to submit to the Insurance Administrator any Supervisor's Incident Investigation Report (SIIR) received on behalf of an employee, regardless of how or where the employee claims an injury occurred. It is also the policy of the DFRS to submit, in writing to the Insurance Administrator, any report received which, in the opinion of DFRS, indicates that the injury is not the responsibility of the employer. One copy of the report must be given to the injured employee.

4.1 Supervisors will immediately report an employee's injury through the chain-of-command to the on-duty District Chief or Shift Operations Chief. Upon certification of an employee's on-duty District Chief or Shift Operations Chief, approved by the Director of DFRS, and based on written certification by an employee's physician, if presented, that an employee is absent due to a service connected injury/illness, the employee shall immediately be placed on administrative leave until a determination concerning eligibility for compensation has been made by the Division of Risk Management, Department of Finance. It is further agreed that if the disability status is denied by the Division of Risk Management, the employee's pay or leave balance shall be adjusted. (Ref: Local 1664 Contract, Article 10, Section 10.1 Service Connected Injury, July 1989).

4.2 To efficiently administer Section 4.1, the Director, Department of Fire and Rescue Services has delegated approval authority to the Bureau Chiefs.

4.3 Assignment to administrative leave may be conveyed via telephone or radio between the Bureau Chief and District/Shift Operations Chief.

4.4 Employees will be charged sick leave whenever the Insurance Adjuster discontinues benefits prior to the employee returning to work.

4.5 Personnel sustaining a work related injury will, when practical, take one copy of form AD88001 (Medical Evaluation of Work Status) to the licensed health care provider and have the form completed by the attending physician. In lieu of the form, a signed note from the health care provider attached to the form will suffice.

4.6 Prior to returning to duty following any work related injury, employees will present Form AD 88001 (Medical Evaluation of Work Status) completed by the licensed health care provider, to the Senior Career Officer. Employees will then be required to be seen by the Employee Medical Examiner at the Occupational Medical Section to be released for duty. In extenuating circumstances, the on-duty Shift Operations Chief or District Chief may waive the return to work requirement.

4.7 For the purpose of applying this policy, off-duty DFRS personnel who are injured while performing an emergency service in Montgomery County, Maryland, attending a Department approved training class, or while participating as a volunteer firefighter/rescuer for a Montgomery County Corporation will be covered as if on-duty.

RESPONSIBILITY

5.0 Employees who become injured or suspect that they may have been injured in the line of duty are responsible for reporting the incident to their supervisor, regardless of how minor the injury may appear.

5.1 Upon notification of any injury, the supervisor is responsible for completing required reports as outlined in Section 6.1 of this Policy. All completed reports will be forwarded to the Senior Career Officer and a copy will be issued to the injured employee.

5.2 The Senior Career Officer is responsible for reviewing all required reports and for submitting all information to the Division of Risk Management.

5.3 The on-duty supervisor is responsible for advising the on-duty District Chief or Shift Operations Chief of the injury and obtaining from them the appropriate pay status to carry the employee on.

5.4 All personnel are responsible for providing pertinent information regarding their medical condition to the Claims Administrator.

5.5 All personnel are responsible for informing their physician and/or hospital, at the time of treatment, to send bills directly to the Claims Administrator or the injured party's Worker's Compensation Attorney for processing. The address for the current Claims Administrator is:

Montgomery County Claims
50 Monroe Street, Suite 301
Rockville, Maryland 20850

5.6 The Senior Career Officer is responsible for sending a memorandum to the Payroll Section if an employee is to be recredited or charged sick leave. This will only be authorized after either Risk Management, the Claims Administrator, or the Workers' Compensation Commission confirms that the claim is compensable. The memorandum must contain the exact date(s) and hour(s) that the employee was off and documentation to substantiate time lost due to the injury. A copy of the memorandum will be issued to the employee.

PROCEDURE

6.0 All employees must immediately report any injury sustained while on duty to their on-duty supervisor.

6.1 The supervisor must complete a Supervisor's Incident Investigation Report (Attachment 7.2) and an Employer's First Report of Injury Form (Attachment 7.1) with full documentation on the circumstances of the injury or illness.

6.2 The employee must review and sign the completed SIIR. A copy must be made and issued to the employee.

6.3 All reports must be submitted to the Senior Career Officer immediately after completion.

6.4 The Senior Career Officer must review, complete, and submit all reports to the Division of Risk Management within four calendar days of receiving them. One Xeroxed copy of the reports must be forwarded to the DFRS Safety Officer. The "Agency" copy must be forwarded to the Bureau of Management Services for inclusion in the employee's personnel file.

6.5 The on-duty supervisor will immediately notify the on-duty District Chief or Shift Operations Chief of the accident. The District/Shift Operations Chief will certify that the injury is job-related as appropriate, and authorize the employee to be carried on administrative leave.

6.6 When practical, an injured employee who requires medical treatment will take one copy of form AD88001 to the medical facility and have the licensed health care provider complete the form.

6.7 An employee who has been awarded a permanent partial disability from the Workers' Compensation Commission will be charged sick leave for subsequent visits to his/her physician for treatment of the compensated injury, unless considered a temporary total disability.

6.8 The employee must complete a Workers' Compensation Commission Form MP-C1 (Attachment 7.3) and submit it to the Worker's Compensation Commission for all injuries that result in more than three consecutive calendar days off from work. By law, employees within two years from the date of an injury or onset of illness may file a claim for less serious injuries.

POLICIES AND PROCEDURES

MONTGOMERY COUNTY

DEPARTMENT OF FIRE AND RESCUE SERVICES

DATE March 7, 1991

DIRECTOR APPROVAL

TITLE WORKERS' COMPENSATION CLAIMS

6.9 Employees who are ready to return to work must submit to the Senior Career Officer a completed Form AD 88001 (Medical Evaluation of Work Status), or a note from the health care provider attached to a Form AD88001.

6.10 Upon receipt of a medical release (as outlined in Section 6.9, above), the Senior Career Officer, will immediately schedule the employee for a back to work physical examination with the Occupational Medical Section.

ATTACHMENT

7.0 Medical Evaluation of Work Status.

7.1 Employer's First Report of Injury Form (CSI FI).

7.2 Supervisor's Incident Investigation Report (SIIR). (3 parts)

7.3 Workers' Compensation Commission Form MP-C1 Employee's Claim.

7.4 DFRS Designators for use on SIIR.

CANCELLATION

8.0 This policy hereby cancels the previous policy on this subject issued on 12/21/89.

8036a

DEPARTMENT OF FIRE AND RESCUE SERVICES
MONTGOMERY COUNTY, MD.

Attachment 7.0

MEDICAL EVALUATION OF WORK STATUS

Name:	Date:	Job Title:
Diagnosis:		This Report Is: First ☐ Extension ☐ Final ☐
Prognosis and Current Treatment:		

☐ QUALIFIED for Full Duty of Job Title ☐ NOT QUALIFIED for Full Duty of Job Title

☐ QUALIFIED for Limited Duty - Specify Below

RESTRICTIONS

_____ Lifting, Carrying up to __________lbs.	_____ Inside, Enclosed, Cramped spaces
_____ Pushing, Pulling	_____ Outside, Weather exposure
_____ Reaching above shoulder	_____ Excessive heat
_____ Use of fingers, Dexterity	_____ Excessive cold, Wind, Dryness
_____ Both hands, Use of __________ hand	_____ Excessive humidity, Dampness
_____ Standing, Walking	_____ Excessive dust, Dirt, Silica
_____ Bending, Stooping, Leaning, Crawling	_____ Excessive noise
_____ Climbing, Using legs only, Stairs, Ramps	_____ Fumes, Smoke, Gases, Odors
_____ Climbing, Using Arms, Ladders, Ropes	_____ Solvents, Grease, Toxic chemicals
_____ Sitting	_____ contact vibration
_____ Visual Acuity	_____ Intense light
_____ Depth perception, Binocular vision	_____ Prolonged, Irregular hours, Shift work
_____ Operation of power machinery	_____ Medications/side effects, explain in remarks
_____ Operation of motor vehicle	_____ Other ____________________
_____ Home rest for __________ days	____________________
_____ Non ambulatory	____________________

Other Remarks:

Date Full Duty Will Resume	Date for Reevaluation	Medical Officer/Physician	Phone #
		Print Name	Signature

Administrative Endorsement of Restricted Assignment

	Date	Senior Career Officer
☐ Restricted Work Assignment is not Available ☐ Restricted Work is Assigned		

AD88001 4/92 White - County Medical Yellow - Personnel File Pink - Employee

WORKERS COMPENSATION EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

CONTAINS ALL ITEMS REQUIRED BY OSHA FORM 101 (Enter all dates in MM/DD/YY format)

OSHA CASE/FILE #

CARRIER CLAIM NUMBER

DO NOT WRITE IN SPACE BELOW

JURISDICTION CLAIM NUMBER

PLEASE CHECK

- MONTGOMERY COUNTY GOVERNMENT
  101 MONROE STREET, ROCKVILLE, MD 20850—217-7240
- MONTGOMERY COUNTY PUBLIC SCHOOLS
  850 HUNGERFORD DRIVE, ROCKVILLE, MD 20850—279-3611
- MONTGOMERY COLLEGE
  900 HUNGERFORD DRIVE, ROCKVILLE, MD 20850—279-5267
- MARYLAND NATIONAL CAPITAL PARK & PLANNING COMMISSION
  6609 RIGGS ROAD, HYATTSVILLE, MD 20782—853-4823
- REVENUE AUTHORITY
  211 MONROE STREET, ROCKVILLE, MD 20850—762-9080
- OTHER

LARS CODE

2 3 4 5

CARRIER (Name, Address & Phone No.)

Montgomery County Maryland
Self Insurance Program
101 Monroe Street
Rockville, MD 20850
301-217-7240

POLICY/SELF-INSURED NUMBER 13151401 — 6

POLICY PERIOD — 7

7/1/78 TO CONTINUOUS

CHECK IF APPROPRIATE SELF INSURANCE STATE FUND — 8

EMPLOYEE

NAME (Last, First, Middle) SOCIAL SECURITY NUMBER PHONE NO. (A/C. No.) — 9

ADDRESS (Include County & Zip) DATE OF BIRTH MARITAL STATUS — 10

VOLUNTEER MALE — 11

ZIP CODE FEMALE

REGULAR DEPT. OR DIVISION DATE HIRED YES NO — 12

OCCUPATION HOW LONG AT CURRENT JOB CERTIFICATE NUMBER (If Under 18) — 13

WAGE INFORMATION

RATE PER: HOUR DAY WEEK MONTH OTHER: — 15

DATE RETURNED TO WORK FULL PAY FOR DAY OF INJURY? YES NO DID SALARY CONTINUE? YES NO — 16

AVERAGE WAGE/WEEK AT TIME OF INJURY DOES EMPLOYEE RECEIVE PAY IN KIND? NO YES (EXPLAIN): — 17

OCCURRENCE

PLACE OF ACCIDENT OR OCCURRENCE (Incl. State) COUNTY OF INJURY DATE OF INJURY/ILL. TIME OF OCCURRENCE AM PM TIME WORKDAY BEGAN AM PM — 18

LAST WORKDATE DATE SUPSV'R NOTIF'D INDIVIDUAL NOTIFIED — 19

EMPLOYER'S PREMISES?

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) — 20

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)

IF FATAL, GIVE DATE OF DEATH: WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? YES NO WERE THEY USED? YES NO

PHYSICIAN (Name & Address)

HOSPITALIZED
OUT-PATIENT
EMERGENCY ROOM
IN-HOUSE TREATMENT
FIRST AID

HOSPITAL (Name & Address)

WITNESS (Name & Phone Number)

DATE OF THIS REPORT PREPARER'S NAME & TITLE SUPV. SIGNATURE PHONE NUMBER (A/C. No., Ext.)

10/05/90

Montgomery County Government
Department of Finance • Division of Risk Management

SIIR SUPERVISOR'S INCIDENT INVESTIGATION REPORT

(Privileged and Confidential)

INDEX NUMBER/DATE RECEIVED 1

SAFETY SECTION USE ONLY

Instructions

1. Follow specific County or Departmental procedures for completing and submitting incident and accident reports.
2. Refer to the detailed instruction on the reverse side of each page of this form.
3. Press hard - you are making three copies.
4. Complete all applicable sections on pages 1, 2, and 3.
5. Detach the goldenrod copy and retain for your records. All other copies and supporting documentation must be forwarded to the Division of Risk Management within 4 days of the incident.

Agency Code

LEAVE BLANK

Department	Division	Section

Ⓐ Type of Incident — Circle All that Apply:

1000- Motor Vehicle Incident
1001- County Vehicle Damage
1002- Occupational Injury/Exposure
1003- Occupational Illness

Complete Only Page 1

1004- Threat to/Breech of Security
1005- Non-Motor Vehicle Liability Incident
1006- Damage to Other County Property (Not Vehicle)

Ⓑ Employee Information

Last Name	First Name	MI	Age

Social Security No.	Official Position Title

Ⓒ Incident Information

...s Date	Incident Date	Time of Incident AM/PM	Vehicle Number (Veh. Incidents Only)

Responsible Supervisor's First Initial	Last Name

Location of Incident

For vehicle incidents indicate intersection or nearest street address

Other SIIR's filed for this Incident? ☐ Yes ☐ No

☐ Check here if the above location is a Montgomery County Government owned or occupied building.

County Property FM#

Ⓓ Description of the Incident in the Employee's Words (at least 25 words; printed or typed)

...loyee's Signature: Date

Supervisor's Signature: Date

Rev 6/90

GOLDEN ROD: Agency Copy
All other copies: Risk Management

SIIR 2

SAFETY SECTION USE ONLY

(E) GENDER OF EMPLOYEE

1007- Male
1008- Female

(F) EMPLOYEE STATUS

1009- Full-time
1010- Part-time
1011- Temporary (FT or PT)
1012- Volunteer
1013- Non-County Employee

(G) LENGTH OF TIME PERFORMING THIS JOB

(Round to the nearest whole number)
1014 0-3 Months
1015 4-6 Months
1016 7-9 Months
1017 10-11 Months
1018 1-2 Years
1019 3-5 Years
1020 6-10 Years
1021 11-15 Years
1022 16-20 Years
1023 Over 20 Years

(H) NUMBER OF HOURS INTO SHIFT WHEN INCIDENT OCCURRED

(Round to the nearest whole number)
1024 0-1 Hour
1025 2-3 Hours
1026 4-5 Hours
1027 6-7 Hours
1028 8-9 Hours
1029 10 Hrs or more
1030 Unknown

(I) TASK BEING PERFORMED AT TIME OF INCIDENT

1031- Construction/Fabrication/Installation/Demolition
1032- Housekeeping
1033- Inspection/Investigation/Testing
1034- Maintenance (Repair) of Building, Building Equipment, or Grounds
1035- Maintenance/Repair/Refueling Highway Vehicle
1036- Maintenance/Repair of Road/Highway
1037- Maintenance/Repair, Other
2075- Moving to/from Location on Foot
1038- Operating Machinery (Including Heavy Equipment)
1039- Materials Handling Operations (Including the Operation of Forklifts)
1040- Office Tasks
1041- Operating/Riding in/on a Motor Vehicle (Not Responding/Returning)
1042- Operating/Using Hand/Power Tools
1043- Physical Fitness Activities/Recreation/Physical Testing (individual Sports)
1044- Physical Fitness Activities/Recreation (Team Sports)
1045- Service Activities, Other
1046- Unauthorized Task
1047- Multiple Tasks or Unknown (Use for Illnesses and Exposures Only, When Applicable)
1048- Other, Not Listed Above: Specify Below:

TASKS SPECIFIC TO PUBLIC SAFETY

1049- Controlling Suspect/Prisoner/Patient
1050- Controlling/Capturing an Animal
1051- Fighting a Fire
1052- Firefighting Drill (Live)
1053- Haz-Mat Incident
1054- Non-Emergency Operations at the Scene of an Incident
1055- Pursuing a Suspect
1056- Rescue Call
1057- Responding to an Emergency
1058- Returning from an Emergency
1059- Training Evolution (Firefighting - See #1052)

OCCUPATIONAL INJURY/ILLNESS/EXPOSURE INFORMATION

(J) INCIDENT CLASSIFICATION

1060- Caught In, Under, or Between
1061- Caught or Trapped in an Enclosed Area
1062- Contact with Electric Current
1063- Contact with Foreign Matter (ie. Dirt in Eyes)
1064- Contact with Sharp Object
1065- Contact with Temperature Extremes (Burns, etc.)
1066- Exposure to Environmental Cold
1067- Exposure to Environmental Heat
1068- Exposure to Fire Products
1069- Exposure to Hazardous Substances/Chemicals
1070- Exposure to Infectious Substances
1071- Fall from Vehicle/Apparatus
1072- Fall into Floor Opening, Open Shaft
1073- Fall on Same Level
1074- Fall to Different Level
1075- Gunshot
1076- Physical Overexertion/Overextension
1077- Public Transportation Accident (in which Injured was a Passenger)
1078- Psychological Trauma
1079- Repetition of Pressure/Motion (ie. Noise, CTS)
1080- Rubbed or Abraded
1081- Slip/Trip (Without Fall)
1082- Struck Against
1083- Struck By
1084- Other, Not Listed Above; Specify Below:

(K) BODILY ACTIVITY AT TIME OF INCIDENT

1085- Bending
1086- Climbing
1087- Crawling
1088- Driving
1089- Jumping/Landing
1090- Kneeling
1091- Lifting
1092- Lying Down
1093- Mounting/Dismounting Vehicle or Equipment
1094- Pulling
1095- Pushing
1096- Reaching or Stretching
1097- Riding
1098- Running
1099- Sitting
1100- Standing
1101- Twisting
1102- Walking
1103- Multiple Actions
1104- Unknown

(L) NATURE OF INJURY/ILLNESS

1105- Abrasion
1106- Amputation
1107- Bite, Animal, Human or Insect
1108- Blunt/Penetrating Trauma
1109- Bruise/Contusion
1110- Burn (Chemical)
1111- Burn (Electrical)
1112- Burn or Scald (Heat)
1113- Concussion/Unconscious
1114- Contagious/Infectious Disease
1115- Cut/Scratch Laceration/Puncture
1116- Dislocation
1117- Electric Shock
1118- Fatality
1119- Foreign Substance
1120- Fracture
1121- Freezing/Frostbite/Hypothermia
1122- Heat Stroke/Stress
1123- Hernia/Rupture
1124- Impaired Sensory Perception
1125- Inflammation
1126- Injection
1127- Irritation
1128- Muscle Spasm
1129- Poisoning, Systemic
1130- Psychological Disorder
1131- Radiation Effects
1132- Separation/Avulsion
1133- Sprain/Strain
1134- Suffocation/Asphyxiation
1135- Other Injury Nature; Specify Below:

(M) BODY PART MOST AFFECTED (SELECT ONE FROM EACH BOX BELOW)

1136- Right
1137- Left
1138- Both
1139- Not Applicable

HEAD/NECK
1140- Ear(s)/Hearing
1141- Eye(s)/Sight
1142- Face
1143- Jaw
1144- Mouth/Teeth
1145- Nose
1146- Scalp/Skull
1147- Neck/Throat

UPPER EXTREMITIES
1148- Arm, Upper or Lower
1149- Elbow
1150- Finger(s)/Thumb
1151- Hand
1152- Wrist

TRUNK
1153- Abdomen
1154- Back, Upper
1155- Back, Middle
1156- Back, Lower
1157- Chest
1158- Groin/Genitalia
1159- Hip/Buttock
1160- Shoulder

LOWER EXTREMITIES
1161- Ankle
1162- Foot
1163- Knee
1164- Leg, Upper
1165- Leg, Lower
1166- Toe(s)

BODY SYSTEMS
1167- Cardiovascular System
1168- Digestive System
1169- Nervous System
1170- Respiratory System
1171- Skin
1172- Entire Body
(Use for Some Illnesses and Exposures)

(N) SOURCE OF INJURY, ILLNESS, OR EXPOSURE

Indicate Below the Specific Object, Substance or Environmental Condition which Caused the Injury, Illness or Exposure.

SAFETY SECTION USE ONLY

(O) CONTRIBUTING CAUSES OF THE INCIDENT: HAZARDOUS CONDITIONS

1173- Actions of Others
1174- Assembly or Design Flaws
1175- Assignment of Personnel/Work Shifts
1176- Atmosphere/Ventilation
..77- Congestion/Housekeeping
.. Dress/Apparel
.. Fire Hazard
1180- Guard or Safety Device
1181- Illumination/Glare
1182- Labeling/Warning
1183- Maintenance
1184- Natural Environment/Weather
1185- Noise
1186- Person Who is Violent/Combative/ Intoxicated/Otherwise Affected
1187- Sharp or Protruding (Not for Knives, Blades, or Other Intentionally Sharp Objects)
1188- Slippery (Not Walking/Working Surfaces)
1189- Storing/Stacking/Securing/Shoring
1190- Tool/Equipment Damage
1191- Walking/Working Surfaces
1192- Worn or Deteriorated
1193- Other Hazardous Condition Not Listed; Specify Below: ____

(P) CONTRIBUTING CAUSES OF THE INCIDENT: UNSAFE ACTS

1194- Acts Relating to Hazardous Conditions
1195- Alteration of Safety Devices
1196- Attention to Footings or Surroundings
1197- Wearing of Personal Attire
1198- Control of Suspect/Prisoner/Patient
1199- Use of Hands or Body Parts
2000- Horseplay
2001- Instructing/Warning
2002- Loading
2003- Method or Procedure
2004- Related to the Use of Personal Protective Equipment
2005- Related to Proper Body Positioning or Posture
2006- Speed of Operation
2007- Use of Tools/Equipment/Furnishings
2008- Training for Job/Task
2009- Other Unsafe Act Not Listed; Specify Below: ____

(Q) INJURY/ILLNESS/EXPOSURE TREATMENT/OUTCOME

2010 On-the-Job Fatality
2011 Incident involving any of the following:
- -Occupational Illness
- -Medical Treatment Administered beyond Immediate or First Aid
- -Restriction of Work Activities (including time away from work)
- -Restriction of Bodily Motion Inhibiting Ability to Perform Job
- -Assignment to Another Job Position
- -Fracture(s)
- -Loss of Conciousness

Where work activities have been restricted, or employee has been assigned to another position as a result of this incident, enter date of first full scheduled workshift affected:

DO NOT INCLUDE THE DAY OF THE INCIDENT. ____

2012 Immediate First Aid or Immediate Medical Treatment Administered Only Cases *WITH*
- -No Restriction of Work Activities or Bodily Motion
- -No Loss of Conciousness
- -No Assignment to Another Job Position
- -No Fractures

2013 No Treatment Required at this Time

Has Medical Documentation of Incident Been Attached to this Report?
Yes
No Reason: ____

Employee's Comments and Corrective Recommendations: ____

Supervisor's Comments: ____

..rvisor: What steps have you taken to prevent a recurrence: (Check Items Completed/Implemented)

☐ Equipment/Environment ____ ☐ Policies/Procedures ____

☐ Education/Training ____ ☐ Other ____

Employee Signature ____ Date ____ Supervisor Signature ____ Date ____

MOTOR VEHICLE INCIDENT INFORMATION

(R) VEHICLE TYPE

2014- Automobile
2015- Bus
2016- Light Truck/Apparatus/Ambulance
2017- Heavy Truck/Apparatus
2018- Heavy Equipment
2019- Motorcycle
2020- Scooter/Cart

(S) GENERAL CLASSIFICATION

2021- Non-Collision Incident

PARKING-RELATED INCIDENTS
2022- County Vehicle Parked - Other Vehicle Moving
2023- Other Vehicle Parked - County Vehicle Moving

NON-PARKING INCIDENTS
2024- Involving a Non-Vehicular Fixed Object
2025- Involving a Pedestrian, Animanl, or Other
2026- County Vehicle in Transit - No Other Involved
2027- County Vehicle in Transit - Other(s) Involved
2028- Involving Another County Vehicle
Other County Vehicle Number ____
2029- Other Type Incident Not Listed Above

(T) TYPE OF COLLISION (Circle The Best Diagram)

(20 30 31 32 33 34 35 36 37 38 39 40 41 42

43- Single Vehicle or Parking Incident
44- Backing Incident
45- Non-Collision
46- Unknown/Other

(U) COUNTY VEHICLE DAMAGE

Indicate Severity.

2047- No Damage to County Vehicle
2048- Minor Damage Only
2049- Functional Damage
2050- Disabling Damage
2051- Unknown

Circle Number to Indicate Area of Primary Damage

(20 52 55 58 REAR 53 56 59 FRONT 54 57 60

(V) ROAD SURFACE

2061- Wet
..62- Dry
2063- Snow or Ice
2064- Mud or Other
2065- Unknown

(W) WEATHER CONDITIONS

2066- Clear or Cloudy Sky (No Precipitation)
2067- Foggy
2068- Raining
2069- Snowing
2070- Other/Unknown

Employee Signature ____ Date ____ Supervisor Signature ____ Date ____

DATE OF LAST DDT ____	2071 RECORDABLE 2072 NON-RECORDABLE	2073 PREVENTABLE 2074 NON-PREVENTABLE	DATE ____ INIT ____

Attachment 7.3

EMPLOYEE'S CLAIM

WORKERS' COMPENSATION COMMISSION

6 NORTH LIBERTY STREET
BALTIMORE, MARYLAND 21201-3785
BALTIMORE PHONE (301) 333-4700
TOLL FREE PHONE 1-800-492-0479 IN MARYLAND
BALTIMORE TTY FOR DEAF 383-7555

Claim No.

Insurance Co. and Code No.

Commission has received	Yes	No
Employer's Report		
Doctor's Report		

Co.

Co. Claim No

First Name | Middle Name | Last Name | 2. Phone No.

Mailing Address | City | County | State | Zip Code

Social Security Number | 5. Sex | 6. Date of Birth | 7. Single ☐ Married ☐ | 8. What was your regular work?

Gross wages or earnings (including Tips, Bonus, Overtime, Allowances) at time of accident Per week | 10. Were you paid full wages for the day of the accident? Yes ☐ No ☐ | 11. What was your work when injured?

2. Full and correct business name of your employer | 13. Nature of Employer's business (type business, work done, kind of trade, etc.)

Complete address | 14. Location where accident occurred

City | State | Zip Code | 15. Name of Foreman | Have you given him/her notice of injury? Yes ☐ No ☐

Employer phone no. | 16. Give date of first day you could not work because of inury or disease even if it was a day you normally do not work.

Date of Accident: month day year 19 at am ☐ pm ☐ | 18. If occupational disease, give date of disablement.

Describe how accidental injury occurred OR describe how occupational disease occurred

What member of your body was injured? | 21. Has injury resulted in amputation Yes ☐ No ☐ | If yes, describe loss

Did you request your employer to provide medical care? Yes ☐ No ☐ | Has he done so? Yes ☐ No ☐ | 23 Have you returned to work? If "Yes", on what date did you return? Yes ☐ No ☐

Name and Address of Attending Physician: | 25. If an Attorney is representing you in this case give his name, address and phone no.

Were you in a hospital? If "Yes", give name and address of hospital: Yes ☐ No ☐

Is this the only Workers' Compensation claim you have filed for this Accident or Occupational Disease? Yes ☐ No ☐ If "No", give claim no.

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 I make the foregoing statement of facts.

KEEP 2ND PAGE FOR YOUR RECORD — READ REVERSE BEFORE SIGNING

DATE ______________________ 19 ______ SIGNATURE ______________________
EMPLOYEE FULL NAME

DO NOT WRITE IN THIS SPACE
ATTENTION: FOR EMPLOYER AND INSURER INFORMATION ONLY

Consideration Date: Unless the compensability of this claim is contested by the filing of issues with the Commision on or before an appropriate award will be passed.

Correct Name of Employer according to Commission Records (if different from Para. 12)

DO NOT WRITE IN SPACE BELOW

1 INS. CO. 1
2 ATTY
3 INS. CO 2
4 ATTY
5 EMPLOYER
6 EMP. ATTY.
7 CLMT. ATTY
8 CAUSE
9 BODY LOC.
10 CLASS CODE
11 N. OF I.
12 INDUSTRY
13 M.I.
14 ILL. EMP.
15 O.D.
16 MEDICAL
17 HEALTH
18
19
20
21
22
23
24
25

IMPORTANT: It is the responsibility of the employee to provide [illegible] of any change of address. Always include cl[illegible] number on any correspondence. Attachment 7.3

DISCLOSURE PURSUANT TO EXECUTIVE ORDER 01.01.1983.18

1. The personal information requested on this form in intended to be used in processing your claim for benefits under worker's compensation laws.
2. Failure to provide the information requested may result in delay of your claim for benefits.
3. You have a right to inspect, amend and correct the information provided on this form pursuant to Sections 1-5 of Article 76A of the Maryland Annotated Code.
4. This form will be made part of your claim file and is generally available for public inspection.
5. The information contained on this form is routinely shared with State, Federal or local government agencies.

QUESTIONS AND ANSWERS ABOUT MARYLAND WORKERS' COMPENSATION LAW

WHAT IS WORKERS' COMPENSATION?
Workers' Compensation is an insurance program which your employer provides you with medical treatment and partial income replacement benefits and for any permanent disability you may have sustained.

WHO PAYS?
If your claim is found to be compensable, your weekly benefits and all medical bills will be paid by your employer or the insurance company, which represents your employer. Do not send bills to the Workers' Compensation Commission.

HOW LONG DO I HAVE TO WORK TO BE COVERED UNDER WORKERS' COMPENSATION?
You are covered from the first day you are on the job.

HOW DO I KNOW IF THE COMPANY I WORK FOR IS COVERED BY WORKERS' COMPENSATION?
[illegible]e upper right hand corner of your claim form will be the [illegible]e of the insurance company covering your employer.

WHEN SHOULD I REPORT THE ACCIDENT?
You should report any accident to your employer immediately. A delay in reporting may affect your claim.

HOW DO I FILE A CLAIM?
If your employer does not have a claim form, the Workers' Compensation Commission will provide you with one and all the necessary information you may need. All forms are provided free of charge.

WHAT DO I DO ABOUT A DOCTOR?
If your employer does not provide a doctor, you may choose your own.

WHO PAYS FOR THE DOCTOR?
Your company will pay for your doctor's visit if the injury was caused by an accident on the job.

WHAT MEDICAL TREATMENT WILL WORKERS' COMPENSATION INSURANCE PAY FOR?
All doctor bills, hospital bills, physical therapy, prescriptions, and necessary expenses are covered by this insurance.

WHEN AM I ENTITLED TO BENEFITS?
You are entitled to benefits if you miss more than three (3) days from work. If you miss more than 14 days, you will be [illegible] for the first three days, provided your employer did not [illegible] you for any of these days. A claim number is assigned [illegible]e Commission and a consideration date is placed on the bottom of the form. The consideration date means we allow your employer or his insurer until that date to raise any objections they may have to your claim.

HOW MUCH WILL MY WEEKLY BENEFITS BE?
You should receive two-thirds of your average weekly wage, but not more than the State's average weekly wage for the year that the accident occurred.

HOW LONG WILL I RECEIVE WEEKLY BENEFITS?
You will receive benefits so long as you are unable to work because of the injury.

WHAT IF MY INJURY PREVENTS ME FROM RETURNING TO MY JOB?
If you are not capable of returning to your job or some other job for which you are qualified, you may be eligible for vocational rehabilitation. Call the Worker's Compensation Commission.

WHAT KIND OF BENEFITS WILL I RECEIVE IF I HAVE PERMANENT DISABILITY?
You will receive weekly benefits based on the type and extent of your permanent disability.

WHAT HAPPENS AFTER I FILE A CLAIM?
If you do not receive any benefits, you may request a hearing before the Workers' Compensation Commission. Your case will be decided by a Commissioner who listens to both sides of the case and determines what benefits if any, you should receive. The Commissioner's decision will be based on the law and facts involved.

DO I HAVE TO HAVE A LAWYER?
You may have an attorney of your choice to represent you, or you may represent yourself. The Commissioner can not be your attorney.

WHO PAYS THE ATTORNEY?
Do not pay money to anyone to assist you with your claim. If you hire a lawyer, the Commission will fix his fee. If an award is made to you, the fee will be deducted from your award and paid separately by the employer or insurance company to the attorney.

WHAT IF I WANT TO HIRE A LAWYER BUT DON'T KNOW ONE?
If you are a resident of Maryland, you may call the Lawyer Referral Service by dialing 539-3112 in Baltimore. You may also check your phone directory for the number of a local lawyer referral service.

THE ABOVE INFORMATION IS INTENDED TO BE ONLY A GENERAL GUIDE ON MARYLAND WORKERS' COMPENSATION.

ATTACHMENT 7.4

DEPARTMENT OF FIRE AND RESCUE SERVICES
DEPARTMENT/DIVISION/SECTION DESIGNATORS
FOR USE ON
SUPERVISOR'S INCIDENT INVESTIGATION REPORT

DEPARTMENT	DIVISION	SECTION
FIRE/RESCUE	ADMIN SERVICES	
FIRE/RESCUE	DIRECTOR	
FIRE/RESCUE	EMERGENCY MGMT	
FIRE/RESCUE	FIELD SUPP SVCS	ADMIN
FIRE/RESCUE	FIELD SUPP SVCS	COMMUNIC
FIRE/RESCUE	FIELD SUPP SVCS	TRAINING
FIRE/RESCUE	FIRE PREVENTION	ADMIN
FIRE/RESCUE	FIRE PREVENTION	EDUCATIO
FIRE/RESCUE	FIRE PREVENTION	FIRE SAF
FIRE/RESCUE	FIRE PREVENTION	INVESTIG
FIRE/RESCUE	FIRE PREVENTION	PLANS RE
FIRE/RESCUE	OPERATIONS	ADMIN
FIRE/RESCUE	OPERATIONS	EMS
FIRE/RESCUE	OPERATIONS DIS1	STA 1
FIRE/RESCUE	OPERATIONS DIS1	STA 12
FIRE/RESCUE	OPERATIONS DIS1	STA 15
FIRE/RESCUE	OPERATIONS DIS1	STA 16
FIRE/RESCUE	OPERATIONS DIS1	STA 19
FIRE/RESCUE	OPERATIONS DIS1	STA 2
FIRE/RESCUE	OPERATIONS DIS1	STA 24
FIRE/RESCUE	OPERATIONS DIS2	STA 10
FIRE/RESCUE	OPERATIONS DIS2	STA 11
FIRE/RESCUE	OPERATIONS DIS2	STA 20
FIRE/RESCUE	OPERATIONS DIS2	STA 26
FIRE/RESCUE	OPERATIONS DIS2	STA 30
FIRE/RESCUE	OPERATIONS DIS2	STA 6
FIRE/RESCUE	OPERATIONS DIS2	STA 7
FIRE/RESCUE	OPERATIONS DIS2	RES 1
FIRE/RESCUE	OPERATIONS DIS3	STA 13
FIRE/RESCUE	OPERATIONS DIS3	STA 14
FIRE/RESCUE	OPERATIONS DIS3	STA 23
FIRE/RESCUE	OPERATIONS DIS3	STA 28
FIRE/RESCUE	OPERATIONS DIS3	STA 29
FIRE/RESCUE	OPERATIONS DIS3	STA 3
FIRE/RESCUE	OPERATIONS DIS3	STA 31
FIRE/RESCUE	OPERATIONS DIS3	STA 33
FIRE/RESCUE	OPERATIONS DIS3	STA 8
FIRE/RESCUE	OPERATIONS DIS3	STA 9
FIRE/RESCUE	OPERATIONS DIS4	RES 2
FIRE/RESCUE	OPERATIONS DIS4	STA 17
FIRE/RESCUE	OPERATIONS DIS4	STA 18
FIRE/RESCUE	OPERATIONS DIS4	STA 21
FIRE/RESCUE	OPERATIONS DIS4	STA 25
FIRE/RESCUE	OPERATIONS DIS4	STA 4
FIRE/RESCUE	OPERATIONS DIS4	STA 40
FIRE/RESCUE	OPERATIONS DIS4	STA 5
FIRE/RESCUE	PLAN/PROG DEVEL	