



EXECUTIVE REGULATION

Montgomery County Fire and Rescue Commission

No.: 29-90

Effective Date.

02/28/91

TITLE: WORKERS' COMPENSATION CLAIMS

Page 1 Of 8

Montgomery County Fire and Rescue Commission Regulation on:

WORKERS' COMPENSATION CLAIMS

Issued by: Montgomery County Fire and Rescue Commission
Regulation No. 29-90

Authority: Code Section 21-4B(e)(3)

Supersedes: No prior regulation

Council Review: Method (2) under Code Section 2A-15
Register Vol. 7, No. 10

Effective Date: February 28, 1991

- SUMMARY:** The proposed Workers' Compensation Claims regulation establishes a uniform method for reporting and filing claims for on-duty injuries and occupational diseases sustained by fire and rescue Corporation volunteers and employees, and Department of Fire and Rescue Services volunteers.
- DEADLINES:** Montgomery County Register Comment: October 31, 1990
Montgomery County Fire Board Approval: October 31, 1990
Fire and Rescue Corporation Comment: October 31, 1990
Dept. of Fire and Rescue Services Comment: Oct. 31, 1990
- ADDRESS:** All comments pertaining to the proposed regulation must be sent to Kevin P. Maloney, Chairman, Montgomery County Fire and Rescue Commission, 12th Floor, 101 Monroe Street, Rockville, MD 20850.
- STAFF:** For further information, you may contact Steve Davis, Executive Director, Montgomery County Fire and Rescue Commission, on 217-2461.
- BACKGROUND:** This regulation establishes a procedure for use by all fire and rescue Corporations and the Department of Fire and Rescue Services to report on-duty injuries and occupational diseases sustained by volunteer personnel and Corporation employees. These personnel are covered by the County's Self-Insurance Program for accidental injury or occupational disease.



EXECUTIVE REGULATION

Montgomery County Fire and Rescue Commission

No.: 29-99

Effective Date:

February 28, 1991

TITLE: WORKERS' COMPENSATION CLAIMS

Page 2 Of 8

Sec. 1. Purpose.

To establish guidelines for the completion and submission of Workers' Compensation claims.

Sec. 2. Applicability.

All employees and volunteers of the Corporations and volunteer personnel of the Department.

Sec. 3. Definitions.

- (a) Claims Administrator. For primary insurance, an independent adjuster under contract to the Division of Risk Management, for the Montgomery County Self-Insurance Program. For secondary insurance, an insurance vendor pursuant to a policy administered by the Montgomery County Fire Board.
- (b) Corporation. A fire or rescue Corporation established in the County, authorized to provide fire, rescue, or emergency medical services.
- (c) Department. Department of Fire and Rescue Services.
- (d) Injury. An accidental injury arising out of and in the course of employment or volunteer service with a Corporation or the Department, as defined by the Maryland Workers' Compensation statute and as interpreted by Maryland case law.
- (e) Insurance Administrator. For primary insurance coverage, the Insurance Administrator is the Montgomery County Division of Risk Management, Department of Finance, under the Montgomery County Self-Insurance Program. For secondary coverage, the Insurance Administrator is the Montgomery County Fire Board.
- (f) Occupational Disease. An ailment, disorder, or illness which is the expectable result of working under conditions inherent in employment or volunteer service with a Corporation or the Department, which may arise out of and in the course of employment or volunteer service, as defined by the Maryland Workers' Compensation statute and as interpreted by Maryland case law.



EXECUTIVE REGULATION

Montgomery County Fire and Rescue Commission

No.: 29-90

Effective Date:

Feb. 28, 1991

TITLE: **WORKERS' COMPENSATION CLAIMS**

Page 3 of 8

- (g) On-duty. Any time that personnel are acting in an official capacity on the scene of an emergency incident in Montgomery County, Maryland, on a dispatched Mutual Aid assignment outside of the County, or are en route to or returning from any fire or rescue incident or official activity.
- (h) Personnel. Volunteer members and employees of the Corporations or volunteer personnel with the Department.
- (i) Responsible Corporate Authority. The Corporation Fire Chief or designee.
- (j) Supervisor. The Officer-in-Charge of personnel at any given time, as designated by the Integrated Emergency Command Structure.

Sec. 4. Policy.

It is the policy of Montgomery County that personnel who are unable to work in their current employment due to sustaining an injury or contracting an occupational disease as a result of having provided volunteer fire, rescue, or emergency medical services on behalf of Montgomery County, will be compensated for lost wages in accordance with Maryland's Workers' Compensation statute.

Sec. 5. Procedure.

- (a) All personnel must immediately report to their supervisor any injury or occupational disease or suspected injury or occupational disease sustained while on duty. Subsequently:
- (1) the supervisor must complete a Supervisor's Incident Investigation Report, a First Report of Injury (Appendices (A) and (B)), and all other applicable forms within his or her area of responsibility. All reports must be submitted to the responsible corporate authority within 48 hours of the injury or onset of occupational disease.



EXECUTIVE REGULATION

Montgomery County Fire and Rescue Commission

No.: 29-90

Effective Date:

Feb. 28, 1991

TITLE: WORKERS' COMPENSATION CLAIMS

Page 4 Of 8

- (2) the responsible corporate authority must submit the reports to the primary Insurance Administrator within 10 days of the occurrence of the injury or onset of the occupational disease. Copies of the reports must also be sent to the affected individual and placed in his or her personal file.
- (b) If the primary Claims Administrator has reviewed the First Report of Injury and has found an injury or occupational disease to be compensable, the primary Claims Administrator will process all related bills for payment. Lost wages will be paid by the primary Claims Administrator, within the limits established by the Workers' Compensation Commission. Secondary coverage for volunteer members, up to the limits of the policy, will be considered by the secondary Insurance Administrator through a separate claim. This secondary coverage does not apply to employees of the Department.
- (c) If the primary Claims Administrator has reviewed the First Report of Injury for a volunteer member and has determined that a claim is not compensable, copies of the documentation must be sent to the secondary Insurance Administrator for consideration. In addition, affected individual may request a hearing before the State Worker's Compensation Commission for a determination on the compensability of the claim, or any other related issue.
- (d) The following requirements apply to Corporation employees:
- (1) Corporation employees who lose time from work due to injuries or occupational disease will be charged Sick Leave in accordance with the Fire and Rescue Corporation Personnel Regulations until the Insurance Administrator, the Claims Administrator, or the Workers' Compensation Commission rules on the compensability of the claim. Department employees acting as volunteers also will be charged Sick Leave if the Claims Administrator discontinues benefits before the employee returns to work.

No.: 29-90

Effective Date:

Feb. 28, 1991

Page 5 of 8



EXECUTIVE REGULATION

Montgomery County Fire and Rescue Commission

TITLE: WORKERS' COMPENSATION CLAIMS

- (2) If the Claims Administrator has reviewed the First Report of Injury and has found the injury or occupational disease of a Corporation employee to be compensable, the individual will be recredited with any Sick Leave charged and placed on disability leave during said period. To recredit sick leave, a memorandum must be sent to the Administration Section, Division of Risk Management, specifying the dates and number of days, the number of hours of each day, and the total number of hours charged. Medical documentation to substantiate the amount of time off must also be attached.
- (3) A Corporation employee who has been awarded a permanent partial disability determination from the Workers' Compensation Commission will be charged Sick Leave for subsequent visits to his or her physician to receive treatment for the compensated injury or occupational disease.
- (e) Personnel who have sustained an injury or contracted an occupational disease must complete and submit a Worker's Compensation Commission Form MP-C1 (Appendix C) to the Workers' Compensation Commission if their recovery requires more than three days off firefighting, rescue, or emergency medical services duty, or off their normal employment. Personnel may file this claim up to two years from the date of filing a First Report of Injury with the Insurance Administrator.
- (f) Personnel who were unable to perform their volunteer duties as a firefighter, rescuer, or provider of emergency medical services as a result of having sustained an injury or having contracted an occupational disease must present certification from their private physician to the responsible corporate authority, attesting that they are fit for duty as a firefighter, rescuer, or emergency medical services provider, before returning to duty following recovery from any job-related injury or occupational disease. If the disability lasts longer than 3 days, they must also obtain certification from the Occupational Medical Section by submitting to a medical examination and providing medical documentation to the



EXECUTIVE REGULATION

Montgomery County Fire and Rescue Commission

No.: 29-90

Effective Date:

Feb. 28, 1991

TITLE: WORKERS' COMPENSATION CLAIMS

Page 6 Of 8

Occupational Medical Section and the Corporation or the Department, as applicable, certifying that they are fit for duty as a firefighter, rescuer, or emergency medical services provider.

Sec. 6. Responsibility.

- (a) Personnel who are injured or contract an occupational disease, or suspect that they may have been injured or may have contracted an occupational disease while on duty, must report the incident to their supervisor, regardless of how slight the injury or occupational disease may seem. They must also complete and submit the required reports.
- (b) Personnel who sustain an injury or contract an occupational disease must submit relevant information regarding their medical condition to the responsible corporate authority of the Corporation or the Director of the Department, as appropriate.
- (c) Personnel who sustain an injury or contract an occupational disease must inform their physician and/or hospital to send bills directly to the primary Claims Administrator for processing, unless otherwise directed.
- (d) When notified of any injury or occupational disease, or suspected injury or occupational disease, the supervisor must complete the required reports.
 - (1) The supervisor should determine if contributory factors led to the injury or occupational disease and note this on the reports.
 - (2) The supervisor should also note in his or her report whether there were any witnesses to the injury or onset of occupational disease.
 - (3) Department supervisors are required to follow this procedure in completing documentation on volunteer personnel.



EXECUTIVE REGULATION

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Page 7 0/8

- (e) The Corporations and the Department must submit to the Insurance Administrator any First Report of Injury received on behalf of their respective personnel, regardless of how or where the injury or occupational disease may have occurred.
- (f) All completed reports must be forwarded to the responsible corporate authority of the Corporation, or the Director of the Department, for their respective personnel.
- (g) The responsible corporate authority is not responsible for initiating the claims process. However, the responsible corporate authority must:
 - (1) review all claims of injuries and occupational diseases, adding information as necessary;
 - (2) ensure that reports are completed accurately and legibly; and,
 - (3) forward all documentation to the Insurance Administrator.
- (h) The Corporations and the Department must also notify the Insurance Administrator in writing of any report received and submitted which, in their opinion, is not the responsibility of the Corporation, the Department, or the County.

Sec. 7. Severability.

If a court of final appeal holds that any part of this regulation is invalid, that ruling does not affect the validity of other parts of the regulation.

Sec. 8. Effective Date.

This regulation is effective 30 days after Council adoption or 90 days after Council receipt if the Council takes no action within 60 days of its receipt.



EXECUTIVE REGULATION

Montgomery County Fire and Rescue Commission

No.:	29-90
Effective Date:	Feb. 28, 1991
Page 8 Of 8	

TITLE: WORKERS' COMPENSATION CLAIMS

Sec. 9. Appendices.

- (A) Supervisor's Incident Investigation Report
- (B) Employee's First Report of Injury
- (C) Workers' Compensation Commission Form MP-C1

Attest:

Kevin P. Maloney
Kevin P. Maloney, Chairman
Fire and Rescue Commission

11/20/90
Date

1546d bm 10/29/90

Approved as to form and legality
Montgomery County, Md. County Attorney's Office
By: J. Stephen McAuliffe
11/15/90

Q CONTRIBUTING CAUSES OF THE INCIDENT: HAZARDOUS CONDITIONS

1173- Actions of Others	1183- Maintenance	
1174- Assembly or Design Flaws	1184- Natural Environment/Weather	
1175- Assignment of Personnel/Work Shifts	1185- Noise	
1176- Atmosphere/Ventilation	1186- Person Who is Violent/Combative/ Intoxicated/Otherwise Affected	
1177- Congestion/Housekeeping	1187- Sharp or Protruding (Not for Knives, Blades, or Other Intentionally Sharp Objects)	
1178- Dress/Apparel	1188- Slippery (Not Walking/Working Surfaces)	
1179- Fire Hazard	1189- Storing/Stacking/Securing/Shoring	
1180- Guard or Safety Device	1190- Tool/Equipment Damage	
1181- Illumination/Glare		
1182- Labeling/Warning		

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

Q INJURY/ILLNESS/EXPOSURE TREATMENT/OUTCOME

2010 On-the-Job Fatality	2012 Immediate First Aid or Immediate Medical Treatment Administered Only Cases WITH -No Restriction of Work Activities or Bodily Motion -No Loss of Consciousness -No Assignment to Another Job Position -No Fractures
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 Consciousness	2013 No Treatment Required at this Time

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. _____

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

Employee's Comments and Corrective Recommendations: _____

Supervisor's Comments: _____

Supervisor: 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

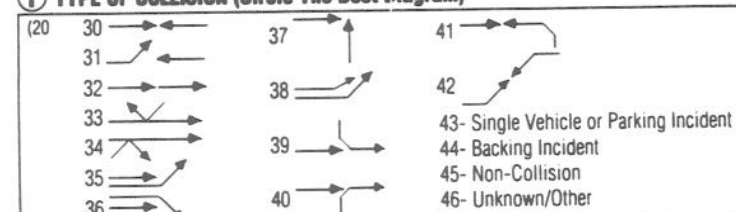
R VEHICLE TYPE

- 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 | NON-PARKING INCIDENTS
2024- Involving a Non-Vehicular Fixed Object
2025- Involving a Pedestrian, Animal, 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 |
| PARKING-RELATED INCIDENTS
2022- County Vehicle Parked - Other Vehicle Moving
2023- Other Vehicle Parked - County Vehicle Moving | |

T TYPE OF COLLISION (Circle The Best Diagram)



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 FRONT
 54 57 60

V ROAD SURFACE

- | | | |
|-----------|--------------------|---------------|
| 2061- Wet | 2063- Snow or Ice | 2065- Unknown |
| 2062- Dry | 2064- Mud or Other | |

W WEATHER CONDITIONS

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

Employee Signature _____ Date _____ Supervisor Signature _____ Date _____

DATE OF LAST DOT _____	2071 RECORDABLE	2073 PREVENTABLE	DATE _____	INT _____
	2072 NON-RECORDABLE	2074 NON-PREVENTABLE		

A copy shall be mailed to the Division of Labor and Industry, 203 E. Baltimore Street, Baltimore, Maryland 21202

STANDARD FORM FOR EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

Complete and send immediately to WORKMEN'S COMPENSATION COMMISSION
107 WASHINGTON STREET, BALTIMORE, MD. 21202

PLEASE PRINT OR TYPE

- 1. Employer Name
2. Mail Address

- PLEASE CHECK
MONTGOMERY COUNTY GOVERNMENT
MONTGOMERY COUNTY PUBLIC SCHOOLS
MONTGOMERY COLLEGE
OTHER

DO NOT WRITE IN THIS SPACE
WCC CLAIM #
DOCTOR'S REPORT Yes No
SOUNDEX #
Federal Employer Identification Number (FEN)
LAIS IDCA CODE

3. Nature of Business
4. TIME AND PLACE
5. Date of injury
6. Was injured paid for one-half or more for Gov of injury?
7. Date disability began
8. INJURED PERSON - Name of injured
9. Address
10. Check () Married Single Widowed Divorced Male Female
11. Nationality Speak English
12. Was this his or her regular occupation?
13. How long employed by you?
14. Wages
15. No. of hours worked per day per week
16. If board, lodging, tips, fuel or other advantages were furnished in addition to wages, give estimated value per day, week or month
17. Nature of injury or occupational disease
18a. Part of body
18b. How did accident or occupational disease occur?
18c. What was employee doing when injured?
19. Probable length of disability
20. Name of object which injured employee
21. Kind of machine power
22. Part of machine on which accident occurred
23. (a) Was safety appliance or regulation provided? (b) Was it in use at time?
24. Was accident caused by injured's failure to use or observe safety appliance or regulation?
25. Has injured returned to work?
26. Name and address of physician
27. Name and address of hospital
28. FATAL CASES - Has injured died?
Date of this report Firm Name Prepared by Signed by Official Title

EMPLOYEE'S CLAIM

Claim No. _____

WORKERS' COMPENSATION COMMISSION
 6 NORTH LIBERTY STREET
 BALTIMORE, MARYLAND 21201-3785
 BALTIMORE PHONE (301) 333-6700
 TOLL FREE PHONE 1-800-482-0479 IN MARYLAND
 BALTIMORE TTY FOR DEAF 363-7555

Insurance Co. and Code No. _____

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

DO NOT WRITE IN SPACE BELOW

Co. Claim No. _____		2. Phone No. _____		1 INS CO 1
First Name _____	Middle Name _____	Last Name _____		2 ATTY
Mailing Address _____		City _____	County _____	State _____
Social Security Number _____		5. Sex _____	6. Date of Birth _____	7. Single Married <input type="checkbox"/> <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	11. What was your regular work? _____
12. Full and correct business name of your employer _____		13. Nature of Employer's business (type business, work done, kind of trade, etc.) _____		3 INS CO 2
Complete address _____		14. Location where accident occurred _____		4 ATTY
City _____	State _____	Zip Code _____	15. Name of Foreman _____	5 EMPLOYER
Employer phone no. _____		Have you given him/her notice of injury? Yes <input type="checkbox"/> No <input type="checkbox"/>		6 EMP. ATTY.
Date of Accident: _____		16. Give date of first day you could not work because of injury or disease even if it was a day you normally do not work. _____		7 CLMT ATTY
month _____ day _____ year 19 _____ at _____		18. If occupational disease, give date of disabiement. _____		8 CAUSE
Describe how accidental injury occurred _____		OR describe how occupational disease occurred _____		9 BODY LOC.
What member of your body was injured? _____		21. Has injury resulted in amputation Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, describe loss _____		10 CLASS CODE
Did you request your employer to provide medical care? Yes <input type="checkbox"/> No <input type="checkbox"/>		Has he done so? Yes <input type="checkbox"/> No <input type="checkbox"/>		11 N. OF I.
Name and Address of Attending Physician: _____		23. Have you returned to work? If "Yes", on what date did you return? Yes <input type="checkbox"/> No <input type="checkbox"/>		12 INDUSTRY
Were you in a hospital? If "Yes", give name and address of hospital: Yes <input type="checkbox"/> No <input type="checkbox"/>		25. If an Attorney is representing you in this case give his name, address and phone no. _____		13 M.I.
Is this the only Workers' Compensation claim you have filed for this Accident or Occupational Disease? Yes <input type="checkbox"/> No <input type="checkbox"/>		If "No", give claim no. _____		14 ILL EMP
If Health Insurance used, give name of Insurance Co. _____				15 O.D.

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 Commission on or before an appropriate award will be passed.
 Correct Name of Employer according to Commission Records (if different from Para. 12)

- 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 employer to provide this information. Always include claim number on any correspondence.

DISCLOSURE PURSUANT TO EXECUTIVE ORDER 01.01.1983.18

1. The personal information requested on this form is 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.

WHAT DO I KNOW IF THE COMPANY I WORK FOR IS COVERED BY WORKERS' COMPENSATION?

In the upper right hand corner of your claim form will be the name 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 paid for the first three days, provided your employer did not pay you for any of these days. A claim number is assigned by the 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.