Attachment B

WORKER'S COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

OSHA CASE/FILE#

GENERAL

EMPLOYER (NAME & ADDRESS INCL ZIP)
Prince George's County Fire/EMS Department
9201 Basil Court, Suite 452
Largo, Maryland 20774

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 #

CARRIER / CLAIMS ADMIN

CARRIER (NAME, ADRESS & PHONE NO)
AIG
P.O. Box 25908
Shawnee Mission, KS 66225
(866) 642-5246

POLICY PERIOD

CHECK IF APPROPRIATE
X SELF INSURANCE

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

CARRIER FIEN | POLICY/SELF-INSURED NUMBER: S-1810 | 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

WAGE

RATE PER: HOUR / MONTH / Week

OTHER:
AVERAGE WAGE/WEEK AT TIME OF INJURY $

DAYS WORKED/WEEK

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 | 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? YES / NO

WERE THEY USED? 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

ACCORD 4 (03/21)

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 ____________

(VDW 03/21)