



# How to Report Employee Work-Related Injuries/Illnesses

All work-related injuries/illnesses must be reported regardless of whether or not the employee seeks treatment. Supervisors of employees who suffer a work-related injury or illness must report this injury or illness.

Reports can be made 24 hours a day, seven days a week by calling 1-888-606-2562. When calling to report the injury/illness, the supervisor will be asked several questions. The following checklist can assist in gathering and reporting the necessary information.

## Call 1-888-606-2562.

A Customer Service Representative will answer the phone you will hear "Thank you for calling the Montgomery County Self Insurance claims reporting Line. This is \_\_. May I have the name of the employer you are calling in reference to?"

You will need the following information when calling in a first report of injury or illness:

1. **Location/Employer** – Identify both the employer and your department name.  
  
Location Code # should be offered if known. \_\_\_\_\_
2. **Employer's Address** – Provide the Department address of the injured/ill employee.  
  
Street Address \_\_\_\_\_  
City, MD Zip Code \_\_\_\_\_
3. **Date of Injury or Illness** – If date is unknown, use the date the injury was first reported to employee's supervisor.  
  
\_\_\_\_\_
4. **Date and time employer notified**  
  
\_\_\_\_\_
5. **Caller's Name** – Your first and last name.  
  
\_\_\_\_\_
6. **Caller's Job Title** – Your job title. (Supervisor, manager, etc.)  
  
\_\_\_\_\_
7. **Caller's Phone Number** – Your phone number.  
  
\_\_\_\_\_
8. **Employee's Social Security Number**  
  
\_\_\_\_\_

9. **Employee's Name** – First, Middle, Last  
  
\_\_\_\_\_
10. **Employee's Home Address**  
  
Street Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip Code \_\_\_\_\_
11. **Employee's Home & Work Phone Number**  
  
Home: \_\_\_\_\_ Work: \_\_\_\_\_
12. **Employee's Date of Birth**  
  
\_\_\_\_\_
13. **Employee's Marital Status**  
  
\_\_\_\_\_
14. **Employee's Gender**  
  
 Male  Female
15. **Employee's Number of Dependents** (do not include the employee in this number).  
  
\_\_\_\_\_
16. **Employee's State of Hire** – Always **Maryland**.
17. **Employee's Job Title**  
  
\_\_\_\_\_
18. **Employee's Work Status**  
  
 Part Time  Full Time
19. **Employee's Date of Hire**

20. **Employee's Date of Termination**  
\_\_\_\_\_
21. **Wage Rate** (if available)  
\$ \_\_\_\_\_
22. **Number of Hours Worked Per Day**  
\_\_\_\_ 7 \_\_\_\_ 8 \_\_\_\_ Other \_\_\_\_\_
23. **Number of Days Worked Per Week**  
\_\_\_\_ 5 \_\_\_\_ Other \_\_\_\_\_
24. **Employee's Supervisor**  
Title \_\_\_\_\_  
Name \_\_\_\_\_  
Telephone \_\_\_\_\_
25. **Be prepared to provide a detailed description of the incident.**
26. **Did injury or illness result in fatality?**  
 Yes  No
27. **If YES, what was the date of death?**  
\_\_\_\_\_
28. **If medical treatment received please provide:**  
Name of the facility, physician, address, and telephone number.
29. **Were there any witnesses to the incident?** If so, please provide name and contact number.
30. **Will the employee miss work beyond the date of injury?**
31. **What date was last worked by the employee?**
32. **Has the employee returned to work? If so, what date?**
33. **Will Employee's salary continue?** (If claim is for lost time and the employee is salaried, will they continue to be paid during period of lost time?)  
 Yes  No
34. **Will employee be paid in full for day of injury?** (If employee is full-time, did they receive full pay for the day? If part-time, did they receive full pay for the time they were scheduled to work?)  
 Yes  No

35. **Address Where Employee Works** – If the address is the same as provided above, indicate that to the Representative. Otherwise, provide the street number, street name, City, State, and Zip Code.

Same as above; or

Street Address \_\_\_\_\_

City, MD Zip Code \_\_\_\_\_

36. **Name of Facility** – Facility where employee works  
\_\_\_\_\_

37. **Department** – Department where employee works  
\_\_\_\_\_

*The Customer Service Representative will then ask the following questions regarding the injury/illness. Be prepared to provide the following information:*

38. **For which state are payroll taxes withheld for the employee?**
39. **What is the claimant's cell number?**
40. **Would you like a fax or email copy of this report?**
41. **What type of medical treatment was received by the employee?**
42. **What is the name of the Union the claimant belongs to?**
43. **Is the injured employee opting to be treated with a network Physician or within the Manage Care Program?**
44. **What is the employee's state of hire?** Always answer "Maryland".
45. **Was the employee treated in an Emergency Room?**
46. **Time the employee began work?**
47. **Additional safety questions asked:** Were safeguards or safety equipment provided, if so the type provided; if not provided, why not. Was the safeguard or equipment used, if so the type used. Would the use of the safety equipment have prevented the injury?

The WC Workers' Compensation Carrier representative is:  
Gallagher Bassett  
Post Office Box 1647  
Rockville, MD 20849  
(301)944-6300