

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?**

The WC Workers' Compensation Carrier representative is:

Gallagher Bassett
Post Office Box 1647
Rockville, MD 20849
(301)944-6300