

FIRST REPORT FORM FOR WORKERS' COMPENSATION

BALTIMORE COUNTY PUBLIC SCHOOLS

1. Call or fax the following information to the Baltimore County Claims Management Unit: phone(410-887-8400) fax(410-887-8426).
2. Maintain a copy for your record.

EMPLOYEE

Name: _____ SSN Number: _____

Address: _____

_____ Home Phone Number : _____

DOB: _____ Sex: M F Marital Status: _____

Job Title: _____ Full-Time: _____ Part-Time: _____

Work Phone Number: _____ Date Hired (M/Y): _____

Supervisor's Name: _____

School/Office/Site Location: _____

Date of Injury: _____

Time Injury Occurred: _____

AM/PM

Type of injury: _____

Part of body injured: _____

Describe how injury occurred: _____

Where did injury occur (e.g., classroom, parking lot, hallway, etc.)? _____

Date Employer Notified: _____

POTENTIAL LOST TIME

Name of Witness(es): _____ Phone Number: _____

_____ Phone Number : _____

Name and Address of Physician/Health Care Provider/Medical Center: _____

PERSON COMPLETING THIS FORM: _____

If employee does not seek medical attention _____
at this time, please have employee sign. Employee's Signature