INSTRUCTIONS
FOR COMPLETING EMPLOYEE FIRST REPORT OF INJURY
FOR OUT OF STATE CLAIMS

This form is only to be used by employees who are injured while working outside the State of Maryland. If you are an Employee Working Out Of State With Special Coverage, use the “Employee’s First Report of Injury FOR OUT OF STATE CLAIMS” form to report an occupational injury or exposure.

Carrier: Zurich American Insurance Company
Policy #: WC 4644150-04

Carrier’s Claims Reporting Phone Number: Phone #: 1-800-987-3373
Fax #: 1-877-962-2567

Insured: University of Maryland Baltimore
Contact: Angela Boxley (410) 706-3221 aboxley@af.umd.edu

STEPS:

1. If necessary, obtain immediate medical assistance. Advise the medical provider this is a workers’ compensation claim. Provide them with the carrier’s name and policy number found above.

2. Complete the Employee’s First Report of Injury form. Fax it to EHS, Angela Boxley, at 410-706-8212.

3. Notify your supervisor as soon as possible. Ask your supervisor to complete the Supervisor’s Report and submit it to EHS as soon as possible.

4. If you will miss any time from work due to your injury, please have your healthcare provider supply a signed medical slip documenting your absence and provide the slip along with any other medical documentation to your supervisor and a copy to EHS.

5. Keep your supervisor and EHS advised of your progress.

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1 EMPLOYEE WORKING OUT OF STATE WHO REQUIRES SPECIAL COVERAGE:

An employee requires special workers’ compensation coverage if the employee is:

- Assigned or permitted to work outside Maryland on a regular basis, with 50% or more of the employee’s UM job-related duties to be Work Out of State. Work at home is Work Out of State if the employee’s residence is not in Maryland.
- Required to Travel on a Recurring Basis to other states to carry out UM employment responsibilities, with 50% or more of the employee’s UM job-related duties to be Work Out of State.
- Assigned or permitted to perform more than 50% of the employee’s UM job-related duties as Work Out of State through a combination of out-of-state work place, out-of-state travel, and out of state work at home.
- Assigned to live and work in a foreign country, with 50% or more of the employee’s UM job-related duties to be performed outside the United States, unless the Employment Contract was Made in the U.S.
Employee’s First Report of Injury
FOR OUT OF STATE CLAIMS ONLY
(To be completed by employee at time of accident)
UNIVERSITY OF MARYLAND BALTIMORE

WC Policy No.: Zurich American Insurance Company      CLAIM #: __________________________
WC 4644150-04

Employee Name: ____________________________________________  EMPL ID: ____________
Last       First                  Middle

Date of Birth: ____________  Marital Status: ____________  Phone: ____________

No. of Dependents: _______  Full Time or Part Time (circle one): FT / PT

Home Address: ____________________________________________
Address   City   State   Zip Code

Supervisor: ________________________________________________
Last       First

When was Accident reported to Supervisor? Date: _______ Time: ______ am / pm

Accident Date: ____________  Time: ____________ am / pm  Time Shift Began: _______

Accident Location: __________________________________________
Address   City   State   Zip Code

Describe fully how accident occurred (your activities at that time): _____________________________
____________________________________________________________________________________
____________________________________________________________________________________

Describe bodily injury and specific part(s) of body affected: _________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Was medical treatment sought? If so, where? __________________________
Address
City   State   Zip Code   Phone

Name(s) of witness(es): __________________________
Name        Phone

Not valid unless signed. By signing this form, I acknowledge that all statements made herein are true

to the best of my knowledge.

Signature of employee: __________________________  Date: ____________

**FAX Immediately to: Angela Boxley at EHS, (410) 706-8212**