Work-Related Injury and Illness Reporting

1022.1 PURPOSE AND SCOPE

The purpose of this policy is to provide guidance regarding timely reporting of work-related injuries and occupational illnesses.

1022.1.1 DEFINITIONS

Definitions in this policy include:

Work-related injury or illness - Accidental personal injury or illness arising out of and in the course of employment (Md. Code LE § 9-101).

1022.2 POLICY

The University of Maryland, Baltimore Police Department will address work-related injuries and occupational illnesses appropriately, and will comply with applicable state workers' compensation requirements (Md. Code LE § 9-101 et seq.).

See attachment: Out of State-First Report of Injury-Sept_2019.pdf

See attachment: SV-Rpt-Sept_2019.pdf

See attachment: Witness-Statement-Sept_2019.pdf

See attachment: Employee's First Report of Injury - EFROI-Form.pdf

1022.3 RESPONSIBILITIES

1022.3.1 MEMBER RESPONSIBILITIES

Any member sustaining any work-related injury or occupational illness shall report such event as soon as practicable, but within 24 hours, to a supervisor, and shall seek medical care when appropriate. Any medical document that the member receives regarding the injury shall be sent to Support Services and/or the UMB Risk Management and Worker's Compensation Office as soon as they are received.

1022.3.2 SUPERVISOR RESPONSIBILITIES

A supervisor learning of any work-related injury or occupational illness shall ensure the member receives medical care as appropriate.

Supervisors must immediately complete and submit the Employee First Report of Injury to the UMB Risk Management and Worker's Compensation Office during the shift in which the incident occurred. The online form will be used unless access to it is unavailable. The online form is available at: https://cfapps.umaryland.edu/erm/firstReportInjury/. Additionally, supervisors must notify Support Services as soon as the Employee First Report of Injury is submitted to the UMB Risk Management and Worker's Compensation Office, as well as immediately notify them when the injured member returns to work from accident leave.

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Supervisors shall ensure that required documents (i.e., Employee's First Report of Injury, detailed memorandum describing the incident, etc.) are completed as soon as practicable and submitted through the chain of command to their respective Bureau Commander/Director for review and processing. Supervisors at each level shall endorse the documents when forwarding them to their respective Bureau Commander/Director.

Supervisors shall determine whether the Major Incident Notification (Policy 327) and the Workplace Safety and Health (Policy 1031) policies apply and take additional action as required.

1022.3.3 DIRECTOR OF SUPPORT SERVICES/SECURITY BUREAU RESPONSIBILITIES

The Director of Support Services/Security Bureau or authorized designee will serve as the Liaison Officer with the Health Risk Manager of the UMB Risk Management and Worker's Compensation Office. The Director of Support Services/Security Bureau or designee will be responsible for ensuring that all required documents are compiled, reviewed for accuracy and completeness, and then forwarding the final internal packet to the UMB Risk Management and Worker's Compensation Office once complete.

1022.3.4 BUREAU COMMANDER/DIRECTOR RESPONSIBILITIES

The Bureau Commander/Director who receives a report of a work-related injury or occupational illness shall review the report for accuracy and determine what additional action should be taken. The reports shall then be forwarded through the chain of command to the Chief of Police. The Director of Support Services/Security shall be copied when submitting the report through the chain of command to the Chief of Police. This will afford the Director of Support Services/Security an opportunity to confer with the Health Risk Manager at the UMB Risk Management and Worker's Compensation Office to ensure UMBPD complies with any required Maryland Occupational Safety and Health (MOSH) Act reporting. Once the appropriate reports are approved by the Chief of Police, the Director of Support Services/Security or designee will be responsible for ensuring the reports are forwarded to the UMB Risk Management and Worker's Compensation Office.

1022.3.5 CHIEF OF POLICE RESPONSIBILITIES

The Chief of Police or authorized designee shall ensure copies of the final report and related documents retained by the department are filed in the member's confidential medical file and retained according to the retention schedule.

1022.3.6 UMB RISK MANAGEMENT AND WORKER'S COMPENSATION OFFICE RESPONSIBILITIES

The UMB Risk Management and Worker's Compensation Office shall ensure the required documents regarding workers' compensation are completed and forwarded promptly to the State Worker's Compensation Commission (Md. Code LE § 9-707).

1022.4 OTHER INJURY OR ILLNESS

Injuries and illnesses caused or occurring on-duty that do not qualify for workers' compensation reporting shall be documented on the designated report (Form 95 or detailed memorandum),

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which shall be signed and endorsed by their supervisor. The report shall be forwarded through the chain of command and a copy sent to the appropriate Bureau Commander/Director.

Unless the injury is extremely minor, this report shall be signed by the affected member, indicating that they desire no medical attention at the time of the report. By signing, the member does not preclude their ability to later seek medical attention.

1022.5 SETTLEMENT OFFERS

When a member sustains a work-related injury or occupational illness that is caused by another person and is subsequently contacted by that person, their agent, insurance company or attorney and offered a settlement, the member shall take no action other than to submit a written report of this contact to their supervisor as soon as possible. The receiving supervisor shall forward the report through the chain of command to the Chief of Police.

1022.5.1 NO SETTLEMENT WITHOUT PRIOR APPROVAL

No less than 10 days prior to accepting and finalizing the settlement of any third-party claim arising out of or related to a work-related injury or occupational illness, the member shall provide the Chief of Police with written notice of the proposed terms of such settlement. In no case shall the member accept a settlement without first providing written notice to the Chief of Police. The purpose of such notice is to permit the department an opportunity to determine whether the offered settlement will affect any claim the UMBPD may have regarding payment for damage to equipment or reimbursement for wages against the person who caused the accident or injury, and to protect the department's right of subrogation, while ensuring that the member's right to receive compensation for injuries is not affected.

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Attachments

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OutofState-FirstReportofInjury-Sept_2019.pdf

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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,[1] 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**

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

Insured: **University of Maryland Baltimore**
Contact: **EHS Risk Management (410) 706-7055 EHSRiskManagement@umaryland.edu**

STEPS:

1. If necessary, obtain immediate medical assistance. Advise the medical provider this is a workers' compensation claim.
2. Complete the Employee's First Report of Injury form. Fax it to EHS, Risk Management 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.

[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: Zurich American Insurance Company **CLAIM #:** ____________________

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: EHS Risk Management, (410) 706-8212

SV-Rpt-Sept_2019.pdf

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Supervisor's Investigation Report

(To be completed by employee's supervisor at time of accident)

UNIVERSITY OF MARYLAND

Location where accident occurred			Employer's Premises: Yes ☐ No ☐ Job site: Yes ☐ No ☐	Date of accident or illness
Who was injured?			☐ Employee ☐ Non-Employee	Time of accident a.m. ☐ p.m. ☐
Length of time with firm	Job title or occupation	Name of dept. normally assigned to	How long has employee worked at job where injury or illness occurred?	
What property/equipment was damaged?			Property/equipment owned by:	
What was employee doing when injury/illness occurred? What machine or tool was being used? What type of operation?				
How did injury/illness occur? List all objects and substances involved.				
Part of body affected/injured?	Any prior physical conditions? If so, what? Yes ☐ No ☐			
Nature and extent of injury/illness and property damaged (be specific)				

PLEASE INDICATE ALL OF THE FOLLOWING WHICH CONTRIBUTED TO THE INJURY OR ILLNESS

____ Failure to lockout
____ Failure to secure
____ Horseplay
____ Improper dress
____ Improper guarding
____ Improper instruction
____ Improper maintenance
____ Improper protective equipment
____ Inoperative safety device
____ Lack of training or skill
____ Operating without authority
____ Physical or mental impairment
____ Poor housekeeping
____ Poor ventilation
____ Unsafe arrangement or process
____ Unsafe equipment
____ Unsafe position
____ Other ____________________

Supervisor's corrective action to ensure this type of accident does not recur: ____

____

____

____

Was employee trained in the appropriate use of Personal Protective Equipment/Proper safety procedures?... Yes ___ No ____

Was employee cautioned for failure to use Personal Protective Equipment/Proper safety procedures? .... Yes ___ No ____

Did employee promptly report the injury/illness? .... Yes ___ No ____

Is there modified duty available? .... Yes ___ No ____

____________________	____________________	____________	________
Supervisor's name	Supervisor's signature	Phone#	Date

***Fax immediately to: EHS Risk Management (410) 706-8212**

Please fill in all fields noted in RED

Witness-Statement-Sept_2019.pdf

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Accident Witness Statement
(To be completed by accident witness)

Employer: **University of Maryland**		
Employee: (First)	**(Last)**	
Location of accident	**Building:**	**Area (hallway, etc.):**
Date of accident:	**Time of accident:**	
Describe fully how accident occurred:		
Describe bodily injury sustained (be specific about part(s) of body affected):		
Name of witness: (First)	**(Last)**	
Witness Phone:		
Signature of witness:		**Date:**

Fax Immediately to: EHS Risk Management (410)706-8212 Revised: 09/19

Employee’s First Report of Injury - EFROI-Form.pdf

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Employee's First Report of Injury

(To be completed by employee at time of accident)

UNIVERSITY OF MARYLAND BALTIMORE

WC Policy No. 910920 **IWIF CLAIM #:**

Employee Name:____ EMPL ID: ___________
Last First Middle

Date of Birth: ____________ Marital Status: ____________________ No. of Dependents: ___

Regular Contingent (circle one) Full Time Part Time (circle one): _______%

Home Address: ____ Phone: _________
Street City State Zip Code

Supervisor: ____________________ When Accident reported to Supervisor: _______________

Accident Date: _________________Time: _______ am pm Time Shift Began:_________

Accident Location: ____
Bldg. Address Area(hallway, etc.)

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

____

____

List injured body parts (be sure to indicate "right" or "left" side): ________________________

____

Was medical treatment sought? If so, where: ____
Name Address

____
City State Zip Code Phone

Safety equipment (list items in use): ____

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

Not valid unless signed. By signing this form, I acknowledge that all statements made herein are true and correct to the best of my knowledge.

Signature of employee: ______________________________________Date: _____________

Fax or Email Immediately to: (410) 706-0954/ UMBRiskManagement@umaryland.edu