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