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| EMPLOYER (NAME AND ADDRESS INCL. ZIP)  Archdiocese of Baltimore  320 Cathedral St.  Baltimore, MD 21201 | | | | | | | | | | | CARRIER/ADMINISTRATOR CLAIM NUMBER | | | | | | | | | | | OSHA LOG CASE NUMBER | | | | | | | | | REPORT PURPOSE CODE | | | |
| JURISDICTION  Maryland | | | | | | | | | | | JURISDICTION CLAIM NUMBER | | | | | | | | | | | | |
| INSURED REPORT NUMBER | | | | | | | | | | | | | | | | | | | | | | | |
| EMPLOYER’S LOCATION ADDRESS (IF DIFFERENT) | | | | | | | | | | | | | | | | | | | | LOCATION # | | | |
| INDUSTRY CODE | | EMPLOYER FEIN | | | | | | | | | PHONE # | | | |
| CARRIER/CLAIMS ADMINISTRATOR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CARRIER (NAME, ADDRESS AND PHONE #.) | | | | | | | | | | | POLICY PERIOD  TO | | | | | | | | | | CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)  RCM&D/SISCO  555 Fairmount Ave.  Towson, MD 21286 | | | | | | | | | | | | | |
|
| CHECK IF APPROPRIATE  SELF INSURANCE | | | | | | | | | |
| CARRIER FEIN | | | POLICY/SELF-INSURED NUMBER | | | | | | | | | | | | | | | | | | | | | | | | ADMINISTRATOR FEIN | | | | | | | |
| AGENT NAME & CODE NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EMPLOYEE/WAGE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NAME (LAST, FIRST, MIDDLE) | | | | | | | | | | | DATE OF BIRTH | | | | | | SOCIAL SECURITY NUMBER | | | | | | | | DATE HIRED | | | | | | | | | STATE OF HIRE  Maryland |
| ADDRESS (INCL. ZIP) | | | | | | | | | | | SEX | | | | | | MARITAL STASIS | | | | | | | | OCCUPATION TITLE | | | | | | | | | |
| M | | | MALE | | | U | | UNMARRIED  SINGLE/DIVORCED | | | | | | EMPLOYMENT STATUS | | | | | | | | | |
| F | | | FEMALE | | | M | | MARRIED | | | | | |
| U | | | UNKNOW | | | S | | SEPARATED | | | | | |
| PHONE | | | | | | | | | | | # OF DEPENDENTS | | | | | | K | | UNKNOWN | | | | | | NCCI CLASS CODE | | | | | | | | | |
|  | | | | | | | |
| RATE $ PER: | | | | | DAY  WEEK | | MONTH  OTHER | | | AVERAGE WEEKLY WAGE  $ | | | | | | | | DAYSWORKED/WEEK | | | | | FULL PAY FOR DAY OF INJURY?  DID SALARY CONTINUE? | | | | | | | | | YES  NO  YES  NO | | |
| OCCURRENCE/TREATMENT | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| TIME EMPLOYEE  BEGAN WORK | AM  PM | | DATE OF INJURY/ILLNESS | | | | | TIME OF OCCURRENCE  Cannot be determined | | | | | | | | AM  PM | | | | LAST WORK DATE | | | | DATE EMPLOYER NOTIFIED | | | | | | | | | | DATE DISABILITY BEGAN |
| CONTACT NAME/PHONE | | | | | | | | TYPE OF INJURY/ILLNESS | | | | | | | | | | | | | | | | | | PART OF BODY AFFECTED | | | | | | | | |
| DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER’S PREMISES? | | | | | | | | TYPE OF INJURY/ILLNESS CODE | | | | | | | | | | | | | | | | | | PART OF BODY AFFECTED CODE | | | | | | | | |
| DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED | | | | | | | | | | | | ALL EQUIPMENT MATERIALS OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED | | | | | | | | | | | | | | | | | | | | | | |
| SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED | | | | | | | | | | | | WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED | | | | | | | | | | | | | | | | | | | | | | |
| HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURE.  THE EMPLOYEE OR MADE THE EMPLOYEE ILL. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | CAUSE OF INJURY CODE | | | | | | |
| DATE RETURNED TO WORK | | | | | | IF FATAL, GIVE DATE OF DEATH | | | | | | | | | WHERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?  WERE THEY USED? | | | | | | | | | | | | | | YES  NO  YES  NO | | | | | |
| PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS) | | | | | | | | | | | | | HOSPITAL (NAME & ADDRESS) | | | | | | | | | | | | | | | | | | INITIAL TREATMENT | | | |
| 0 | | NO MEDICAL TREATMENT | |
| 1 | | MINOR: BY EMPLOYER | |
| 2 | | MINOR CLINIC/HOSP | |
| 3 | | EMERGENCY CARE | |
| 4 | | **OVERNIGHT HOSPITALIZED**. | |
| 5 | | FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED | |
| **OTHER** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| WITNESSES (NAME & PHONE # ) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DATE ADMINISTRATOR NOTIFIED | | | | DATE PREPARED | | | | | PREPARER’S NAME AND TITLE | | | | | | | | | | | | | | | | | | | | | PHONE NUMBER | | | | |