|  |  |  |  |
| --- | --- | --- | --- |
| EMPLOYER (NAME AND ADDRESS INCL. ZIP)Archdiocese of Baltimore320 Cathedral St.Baltimore, MD 21201 | CARRIER/ADMINISTRATOR CLAIM NUMBER | OSHA LOG CASE NUMBER | REPORT PURPOSE CODE |
| JURISDICTIONMaryland | 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 PERIODTO | CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)RCM&D/SISCO555 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 HIREMaryland |
| ADDRESS (INCL. ZIP) | SEX  | MARITAL STASIS | OCCUPATION TITLE |
| M | MALE | U | UNMARRIEDSINGLE/DIVORCED | EMPLOYMENT STATUS  |
| F | FEMALE | M | MARRIED |
| U | UNKNOW | S | SEPARATED |
| PHONE | # OF DEPENDENTS | K | UNKNOWN | NCCI CLASS CODE |
|  |
| RATE $ PER:  | [ ]  DAY[x]  WEEK | [ ]  MONTH[ ]  OTHER | AVERAGE WEEKLY WAGE$ | DAYS WORKED/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? | [x]  YES [ ]  NO[x]  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 |