

Initial Claim - Attorney



The Initial Claim form is the precursor to much of what happens in CompHub and Workers' Compensation claims in the State of Maryland as a whole. This form can be completed completely in the application or printed and signed just like it always has been. Follow these instructions to complete both.

Basic Information

Case Number: CA1279 Date: 09/19/2023

Claimant

First, we need some information about the claimant. Please also check the accuracy of the names and date of birth.

First Name: Johnny Middle Name: Last Name: Impact Suffix: Please select...
Date of Birth: 08/20/2012 Gender: Please select... Marital Status: Please select... SSN: 123456789

Claimant Contact Information

Email: johnnyimpact@gmail.invalid
Phone Number: 4108645100 Ext: Country Code:
Address: Country: US Address Line 1: 10 East Baltimore Street State: MD Address Line 2: Address Line 3: City: Baltimore Postal Code: 21202
[Verify Address](#)

Employer

REQUIRED: Select Advanced Search to provide the details of the employer for whom the claimant was working at the time of the accident. If the employer is not already located in Commission records, also use the Advanced Search button to enter the new employer.

[Advanced Search](#)

To delete / edit a particular row, select the corresponding row and then click on the appropriate icon (delete / edit).

Employer

No records

Is the workplace different from employer's location? Yes No

Claim Information

This section describes the accident or occupational disease and how it occurred. The information provided here is used to determine whether the accident or occupational disease is work-related in the event that the claim goes to a hearing.

Type of claim: Accidental Injury Occupational Disease/Illness Date / Time of accident: 09/15/2023 1:00 pm
Please describe the accidental injury:
Where were you when you were injured?
Is the address where you were injured different than your workplace address? Yes No Injury Location:
To delete / edit a particular row, select the corresponding row and then click on the appropriate icon (delete / edit).

Injured Body Parts Affected

Area of body	Major part of body	Specific body part identifier
Upper Extremities	Wrist	Injury to Left Wrist

Was amputation required? Yes No
Did you notify someone at the time? Yes No
1st day you didn't work: MM/dd/yyyy Date returned to work: MM/dd/yyyy

Job

Please describe the job the claimant was hired to perform for the Employer at the time of accident or occupational disease. If this claim goes to hearing, this information will help the Maryland WCC determine whether the accident or occupational disease is work-related and may affect the amount of any award.

Gross wages per week: Paid full wages for day? Yes No
What is your regular work? What was your work when injured?

Medical Care

This section details any treatment received by the claimant relating to the incident.

Was medical care provided to the claimant? Yes No
Were you treated at a hospital? Yes No If Health Insurance used, give name of Insurance Co.:
To enter the name of a facility, please use the Search Provider option.
To enter the name of a healthcare practitioner, please use the Add Practitioner option.
[Search Provider](#) [Add Practitioner](#)
To delete / edit a particular row, select the corresponding row and then click on the appropriate icon (delete / edit).

Healthcare Provider / Practitioner

No records

Attach Additional Files

DO NOT attach the page 2 Medical Authorization in this step or your claim will be dismissed. This is the step to attach additional related documents if you ran out of room in one of the fields.

Please click + icon below to add new supporting document(s)
All attachments should be converted to PDF format before uploading
To delete / edit a particular row, select the corresponding row and then click on the appropriate icon (delete / edit).

Attachments

No records

Power of Attorney

Check this box if you wish to register the Claimant as a CompHub User. This will allow the claimant to sign certain documents electronically when you select the routing process in CompHub. The claimant will need a cell phone to receive a verification code when signing in.
Are you submitting a signed power of attorney for this claim? Yes No
Will you be uploading a signed copy of the claim form? If you select 'Yes' you will complete the claim form and after you submit it, you will be able to print the pdf of the claim form. In your inbox, will be a task to complete the process. When you have the signed claim form, you will use the task to upload the signed claim form and submit the claim to the Commission. The date of filing will be the date the signed claim form, including the signed authorization for disclosure of health information, is electronically submitted to the Commission provided it is successfully verified. Yes No

Certifications and Signature

Public employee - Was the claimant injured while working as an employee of a unit or an instrumentality of the State or of a political subdivision? Yes No

1 The basic Claimant Information is entered on the Start Form. Any information entered in the Address section should be verified by Clicking/Tapping Verify address.

2 Search for an Employer by clicking Advanced Search, if the Employer is not already in Commission records you can also request the employer be added. If the workplace is different then the employer's registered location you will need to enter that address.

3 Enter the accident/illness description and add the body parts in the Claim Information section.

4 Enter any Medical Information in the Medical Care section. Providers and Practitioners are searched/requested for the same way as Employers. Add Any supporting Documentation with a brief concise description (e.g. Discharge Summary)

5 Electronic: Attach the signed power of attorney and Sign. To Upload the Claim Form: Complete steps 1-4 and select No for POA and 'Yes' for the upload option. CompHub will generate the Claim Form and Med. Auth with a blank line for signature.

Initial Claim - Attorney

Uploading the Form

Upload Signed Claim Form Initial Claim

Signed Claim Form

Download Claim Form: Claim Form.pdf

Upload Signed Claim Form: No files uploaded

2 Once you've obtained the signatures, click the upload icon to upload the signed copy. The submission date will be the date this task is completed.

If you need to come back to upload the form, don't worry; you can come back to the "Upload Signed Claim Form" task for your claim. and upload the signed copy.

1 Click "Claim Form" to download the Form. I recommend renaming the file to something easy to identify.

EMPLOYEE'S CLAIM WORKERS' COMPENSATION COMMISSION

10 E. Baltimore St., Baltimore, MD 21202-1641
BALTIMORE PHONE 410-864-5100
Toll Free (MD): 1-800-492-0479
TTY USERS CALL VIA MARYLAND RELAY

DATE STAMP RECEIVED

CLAIM NUMBER CLAIM STATUS

PERSONAL INFORMATION

Claimant First Name: John Middle Name: Claimant Last Name: Cerna Suffix: Phone Number: []

Street Address: 10 East Baltimore Street City: Baltimore County: State: MD Zip Code: 21202

Social Security Number: [] Sex: [] Date of Birth: 09/05/2023 Marital Status: [] Gross Wages Per Week: \$400.00 Paid full wages for day? Y

What is Your Regular Work? bartending What Was Your Work When Injured? bartending

EMPLOYER INFORMATION

Full And Correct Business Name Of Your Employer: 10 30 WEST NORTH AVENUE LLC Complete Address: 1714 N CHARLES ST BALTIMORE MD 21201-5802 Nature of Business: Drinking Places (Alcoholic Beverages) Phone: []

Notice of Injury Given? [] Location Where Accident Occurred: 10 30 W NORTH AVE BALTIMORE MD 21201-5904

Whom Did You Notify Of The Accident? [] First Day Not Worked: [] Occupational Disease? N Date Of Accident/Occupational Disease Disabling: 09/19/2023 Time: 09:46 AM

Description Of How Accident/Occupational Disease Occurred: []

NOTE: Failure to disclose information or giving false information, including information regarding any work-related activity or return to work either before or after an award of benefits, may subject you to fines, imprisonment, or both, and disqualify you from receiving benefits. A CLAIMANT'S FAILURE TO COMPLETE THIS FORM IN COMPLIANCE WITH THE DIRECTIONS MAY RESULT IN THE CLAIM BEING REJECTED. TO EXPEDITE THIS CLAIM, YOU MAY SEND A COPY OF THE COMPLETED FORM TO YOUR EMPLOYER.

CLAIM INFORMATION

What Member Of your Body Was Injured? Injury to Left Hand Amputation Required? N Medical Care Provided? N Date Returned To Work: []

Physician Name: [] Physician Address: [] Hospital Name: [] Hospital Address: []

Name Of Health Insurance Co. Used: []

I affirm the electronic signature below to be the signature of the claimant for all purposes under the Maryland Workers' Compensation Law, Title 9 of the Labor & Employment Article of the Annotated Code of Maryland and the Maryland Uniform Electronic Transactions Act, Title 21 of the Commercial Law Article of the Annotated Code of Maryland, including the Authorization for Disclosure of Health Information.

I hereby certify that I have read the information on this form and by signing and submitting this claim for compensation for an injury resulting in my disability due to an accident (or disease) arising out of and in the course of my employment, I solemnly affirm under the penalties of perjury that the contents of the foregoing form are true to the best of my knowledge, information, and belief.

Claimant Signature: [] Email: devinmaxwell@gmail.invalid

Name of Counsel: Devin Maxwell Email of Counsel: dmaxwell@wcc.state.md.us



CA1277

Claim



Upload Signed Claim Form