

STATE OF MARYLAND
MILITARY DEPARTMENT
Fifth Regiment Armory
Baltimore, Maryland 21201-2288

MD Military Department Policy
Number 5-17

1 January 1997

Management

ON THE JOB ACCIDENT REPORTING AND CLAIMS MANAGEMENT
FOR STATE EMPLOYEES

1. General. It is the responsibility of this Department to provide a safe workplace for all of its employees. It is likewise the department's responsibility to assure that an employee who is injured on the job receives prompt and effective medical treatment so that he/she may return to work at the earliest possible date. To this end, the following policies and principles are established to reduce lost time accidents to the lowest possible level.

2. Claims Management.

a. The management of claims begins with the first notification that there has been an accident or that there has been an injury on the job.

b. All accidents involving state employees will be reported to the Department's Personnel Office even though no injury resulted.

c. Employees are to be instructed to report any accident or work-related injury or illness immediately to their supervisor or anyone else in authority.

d. Each facility of the Department will locate and designate a medical treatment provider (local doctor, clinic, emergency room) to furnish care for any work related injuries. This medical treatment provider is to know that treatment for Military Department employees will be under the provisions of the Worker's Compensation Law and that the local department facility is the proper point of contact for the authorization of treatment. They should also know that they should send reports and bills concerning compensation cases to the local facility who will then forward this information to the Personnel Office for processing.

*This policy supersedes MD Mil Dept Policy 5-17 dated July 9, 1991

e. All personnel at each facility should know where to take an employee who is injured on the job.

f. A close relationship with the medical provider could assist in getting the employee treated and back on the job in a timely manner.

g. All employees at every facility should be trained in First Aid, and First Aid supplies are to be immediately accessible for any emergency.

h. The appointing authority may require an employee on a work related accident leave to be examined periodically by a physician selected or accepted by the appointing authority to determine the employee's progress and the length of time necessary for the employee's recovery.

i. Involvement in the treatment at the supervisor level is encouraged to assure prompt care for the employee and to forestall malingering at the encouragement of health care personnel. In such an event, additional information about medical care can be obtained from the Personnel Office.

j. All personnel, especially supervisors, should continually evaluate work situations in terms of safety and constantly advise or train employees in performing their duties in a safe manner. This concern may be carried to the point of formal disciplinary action for those employees who fail to heed directions for safe work practices. This positive approach to safety will raise the awareness of safe work practices in all employees and will stress the point that management does care about the well being of all its workers.

k. It is important to show employees that the Department cares about them not only as a worker but as a person. All employees should be encouraged to participate in health programs and activities such as those sponsored by Club Maryland.

3. Accident Procedures.

a. Upon notification of an accidental injury, the supervisor of a state employee, anyone else in authority, or the employee's co-worker will take whatever steps are necessary to have First Aid administered to the injured.

b. The supervisor will arrange for immediate transportation of any injured employee to a medical treatment facility for examination and care. The supervisor or someone acting on his/her behalf will accompany the injured to the treatment facility.

c. The supervisor or someone acting on his/her behalf will immediately notify the State Personnel Office, 410-234-3838 during normal duty hours of the accident. During non-duty hours notify the duty officer, Emergency Operations Center, 866-400-6364 who will notify the State Personnel Office on the next duty day.

d. Depending upon the severity of the accident, the Personnel Office will notify other offices of the Department of the event.

4. Accident Investigation.

a. The state Personnel Office of the Department is to be immediately notified of any injury that occurs to a State employee whether or not it is judged to be in the actual course of employment.

b. The Personnel Officer may visit the accident scene and the injured employee as soon as possible but preferably the same day as the accident.

c. The scene of the accident will be secured pending the investigation of the accident and until it is released by the state Personnel Officer.

d. The immediate supervisor of the injured will take an active role in the accident investigation to include arranging for the presence of witnesses for the investigation and the completion of the Supervisor's Report of the accident.

e. The Personnel Officer may otherwise direct the completion of the Employee's Report of Injury (Appendix A), the Supervisor's Report of Injury (Appendix B), the Accident Witness Statement (Appendix C), and provide additional guidance as to other documents that may be needed.

f. Reporting the accident to the Injured Worker's Insurance Fund will be completed by the Personnel Officer who will make all of the filings of the accident report to the various state agencies concerned.

g. The injured employee is to be assured that both the supervisor and the Department are concerned about his/her misfortune; and that they will do everything possible to insure proper and complete medical treatment and a speedy recovery.

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h. The employee will make a statement (reduced to writing by the investigator and signed by the employee) setting out exactly the circumstances that led to the injury. Particular attention is to be paid to unsafe procedures, unsafe premises and unsafe equipment.

i. Arrangements will be made with the medical treatment facility to have diagnosis, prognosis and bills sent to the Department.

j. Arrangements will be made between the investigator and the supervisor (if they are different) to insure frequent and timely visits to the injured and one or the other will act on any requests the injured may have.

k. All information will be reported to the Injured Worker's Insurance Fund within 72 hours of the time of injury by the State Personnel Office.

l. The injury will be entered into the Department's computer program data base for future use under the Risk Management Program of the Department.

m. Continuing liaison is maintained between the Department and the Injured Worker's Insurance Fund for guidance and assistance in controlling the resulting claim and sources of help in preventing similar accidents.

n. Any and all collateral forms and reports necessary for the processing of the injury claim will be made by the Department's Personnel Office.

o. The Personnel Officer will represent the Department as an observer or witness at any and all official hearings concerning an employee's injury and its disposition in addition to any subpoenaed witnesses.

p. The supervisor and/or other witnesses that may be called upon to testify at any hearing or trial will notify the Personnel Office of such a request so that the proper leave may be credited and, as appropriate, transportation and travel arrangements can be coordinated.

5. Managing Injured Employees.

a. Supervisors should stay in constant touch with an injured employee and his family, perhaps as often as daily visits. In this manner, the employee will know that there is a sincere interest in his well being and that his contribution to the overall effort of the operation is important. This also places the supervisor in a position to report on the medical progress of the employee.

b. All concerns of the employee as to continued pay and benefits are to be reported as they arise and acted upon immediately.

c. Assistance to the employee's family should be offered if that assistance can be provided within the capability of the Department and the rules and laws that govern those assets.

d. When appropriate, medical information and assistance in the form of second opinions, therapy, and retraining, can be obtained through the Personnel Office.

e. Supervisors will identify those aspects of the injured worker's position that can be performed while recuperating from an injury. "Light Duty" position descriptions will be drafted for each general classification and filed with the Personnel Office. Draft position descriptions will be further modified to fit an actual occurrence and type of injury sustained when the performance of light duty is in the best interest of the injured employee and the Department.

f. An employee who has sustained three or more injuries on the job will be provided additional training in the safe conduct of his work activities.

g. An employee who fails to follow safe work procedures in which he/she has been trained is subject to disciplinary action.

6. Required Reports.

a. Basically, for all on the job injuries only the Employee's Report of Injury, Exhibit A, (Appendix A), the Supervisor's Report of Injury, Exhibit B, (Appendix B), and the Accident Witness Statement, Exhibit C, (Appendix C), need be completed and mailed to the State Personnel Office, Military Department, Fifth Regiment Armory, Baltimore, Maryland 21201-2288.

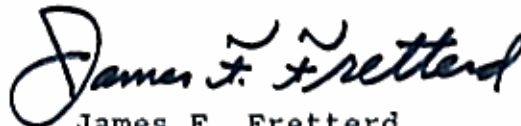
b. For as many instances as possible, Witness Statements should accompany the reports indicated in a. above.

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c. If the injury concerns the use of a state government or federal government motor vehicle, the appropriate accident report forms, such as the ACORD 2, Automobile Loss Notice (Appendix D), or the SF 91, Motor Vehicle Accident Report (Appendix E), must be completed and submitted to the appropriate safety/claims office in this Department's headquarters.

d. If the accident involves injury or property damage to others, their names and addresses are to be reported to the safety/claims office in this Department's headquarters.



James F. Fretterd
Lieutenant General (MD), MDNG
The Adjutant General

Appendices: A - Employee's Report of Injury
B - Supervisor's Report of Injury
C - Accident Witness Statement
D - ACORD 2, Automobile Loss Notice
E - SF 91, Motor Vehicle Accident Report

Distribution:

A



INJURED WORKERS' INSURANCE FUND

Employee's Report of Injury

EXHIBIT A

(To be completed by the employee)

Employer: _____

Address: _____ Pol.# _____

City: _____ State: _____ Zip Code: _____

Employee's name: _____ Sex: _____
Last First Middle

Date of birth: ___/___/___ Home Telephone # () _____

Home address: _____

Present job title: _____

How long employed here: _____

Social Security No.: _____ Bi-weekly salary: _____

Date of accident: _____ Time of accident: _____

Location of accident: _____
(address) Area (hallway, etc.)

Describe fully how accident occurred: _____

(continue on other side, if necessary)

Describe bodily injury sustained (be specific about body part(s) affected): _____

(continue on other side, if necessary)

Name(s) of witness(es): _____

Recommendation on how to prevent this accident from recurring: _____

Name of Supervisor: _____
Last First Middle

When did you report the accident to your supervisor? _____

Signature of employee: _____ Date: _____



Supervisor's Report of Injury

(To be completed by the employee's supervisor or other responsible administrative official)

Employer: _____

Address: _____ Pol.# _____

City: _____ State: _____ Zip Code: _____

Injured employee: _____ SS#: _____
Last First Middle

Date of accident: _____ Time of accident: _____

Location of accident: _____
Address Area (hallway, etc.)

Describe fully how accident occurred: _____

(continue on other side if necessary)

Describe bodily injury sustained (be specific about body part(s) affected): _____

(continue on other side if necessary)

Witnesses to injury:

Name: Job Title: Phone:

(attach witness statements)

Recommendation on how to prevent this accident from recurring: _____

Do you agree with the employee's version of the incident? Yes _____ No _____

If no, explain: _____

Name of supervisor: _____ Position: _____

Home address: _____ SS#: _____

Telephone #: _____ How long employed here? _____

Signature of supervisor: _____ Date: _____



INJURED WORKERS' INSURANCE FUND

Accident Witness Statement

EXHIBIT C

(To be completed by accident witness)

Employer: _____

Address: _____ Pol.# _____

City: _____ State: _____ Zip Code: _____

Injured employee: _____ SS#: _____
Last First Middle

Name of witness: _____ SS#: _____
Last First Middle

Job title: _____ How long employed here: _____

Home address: _____

Home telephone # () _____

Location of accident: _____
Address Area (hallway, etc.)

Date of accident: _____ Time of accident: _____

Describe fully how accident occurred: _____

(continue on other side, if necessary)

Describe bodily injury sustained (be specific about part(s) of body affected): _____

(continue on other side, if necessary)

Recommendation on how to prevent this accident from recurring: _____

Name of supervisor: _____
Last First Middle

Signature of witness: _____ Date: _____

ACORD. AUTOMOBILE LOSS NOTICE

DATE (MM/DD/YY)

PRODUCER	PHONE (A/C, No., Ext.)	COMPANY	MISCELLANEOUS INFO (Site & location code)		
POLICY NUMBER		REFERENCE NUMBER	CAT #		
CODE:	SUB CODE:	EFFECTIVE DATE	EXPIRATION DATE	DATE OF ACCIDENT AND TIME	AM FM
AGENCY CUSTOMER ID:		CONTACT		CONTACT INSURED	PREVIOUSLY REPORTED YES NO
INSURED NAME AND ADDRESS		CONTACT NAME AND ADDRESS		WHERE TO CONTACT	
RESIDENCE PHONE (A/C, No.)		BUSINESS PHONE (A/C, No., Ext.)	RESIDENCE PHONE (A/C, No.)	BUSINESS PHONE (A/C, No., Ext.)	WHEN TO CONTACT

LOSS

LOCATION OF ACCIDENT (Include city & state)	AUTHORITY CONTACTED: REPORT #:	VIOLATIONS/CITATIONS
DESCRIPTION OF ACCIDENT (Use reverse side, if necessary)		

POLICY INFORMATION

BODILY INJURY (Per Person)	BODILY INJURY (Per Accident)	PROPERTY DAMAGE	SINGLE LIMIT	MEDICAL PAYMENT	OTC DEDUCTIBLE	OTHER COVERAGE & DEDUCTIBLES (UM, no-fault, towing, etc)
LOSS PAYEE					COLLISION DED	

UMBRELLA EXCESS	UMBRELLA	EXCESS	CARRIER	LIMITS:	PER CLAIM	PER OCCUR
INSURED VEHICLE						
VEH #	YEAR	MAKE:	MODEL:	BODY TYPE:	VIN:	PLATE NUMBER STATE
OWNER'S NAME & ADDRESS		DATE OF BIRTH		DRIVER'S LICENSE NUMBER	STATE	RESIDENCE PHONE (A/C, No.), BUSINESS PHONE (A/C, No., Ext.)
DRIVER'S NAME & ADDRESS (Check if same as owner)		RELATION TO INSURED (Employee, family, etc.)		DATE OF BIRTH	DRIVER'S LICENSE NUMBER	STATE
PURPOSE OF USE		USED WITH PERMISSION				

DESCRIBE DAMAGE	ESTIMATE AMOUNT	WHERE CAN VEHICLE BE SEEN?	WHEN CAN VEH BE SEEN?	OTHER INSURANCE ON VEHICLE
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PROPERTY DAMAGED

DESCRIBE PROPERTY (If auto, year, make, model, plate #)	OTHER VEH/PROP INST	COMPANY OR AGENCY NAME:
OWNER'S NAME & ADDRESS	YES NO	POLICY #:
OTHER DRIVER'S NAME & ADDRESS (Check if same as owner)	RESIDENCE PHONE (A/C, No.), BUSINESS PHONE (A/C, No., Ext.)	

DESCRIBE DAMAGE	ESTIMATE AMOUNT	WHERE CAN DAMAGE BE SEEN?
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INJURED

NAME & ADDRESS	PHONE (A/C, No.)	INS OTH VEH VEH	AGE	EXTENT OF INJURY
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WITNESSES OR PASSENGERS

NAME & ADDRESS	PHONE (A/C, No.)	INS OTH VEH VEH	OTHER (Specify)
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REMARKS (Include adjuster assigned)

REPORTED BY: _____ REPORTED TO: _____ SIGNATURE OF PRODUCER OR INSURED: _____

MOTOR VEHICLE ACCIDENT REPORT	Please read the Privacy Act Statement on Page 3.	INSTRUCTIONS: Sections I thru IX are filled out by the vehicle operator. Section X, Items 72 thru 82c are filled out by the operator's supervisor. Sections XI thru XIII are filled out by an accident investigator for bodily injury, fatality, and/or damage exceeding \$500.
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SECTION I - FEDERAL VEHICLE DATA

1. DRIVER'S NAME (Last, first, middle)		2. DRIVER'S LICENSE NO./STATE LIMITATIONS		3. DATE OF ACCIDENT	
4a. DEPARTMENT/FEDERAL AGENCY PERMANENT OFFICE ADDRESS				4b. WORK TELEPHONE NUMBER ()	
5. TAG OR IDENTIFICATION NUMBER	6. EST. REPAIR COST \$	7. YEAR OF VEHICLE	8. MAKE	9. MODEL	10. SEAT BELTS USED <input type="checkbox"/> YES <input type="checkbox"/> NO
11. DESCRIBE VEHICLE DAMAGE					

SECTION II - OTHER VEHICLE DATA (Use Section VII if additional space is needed.)

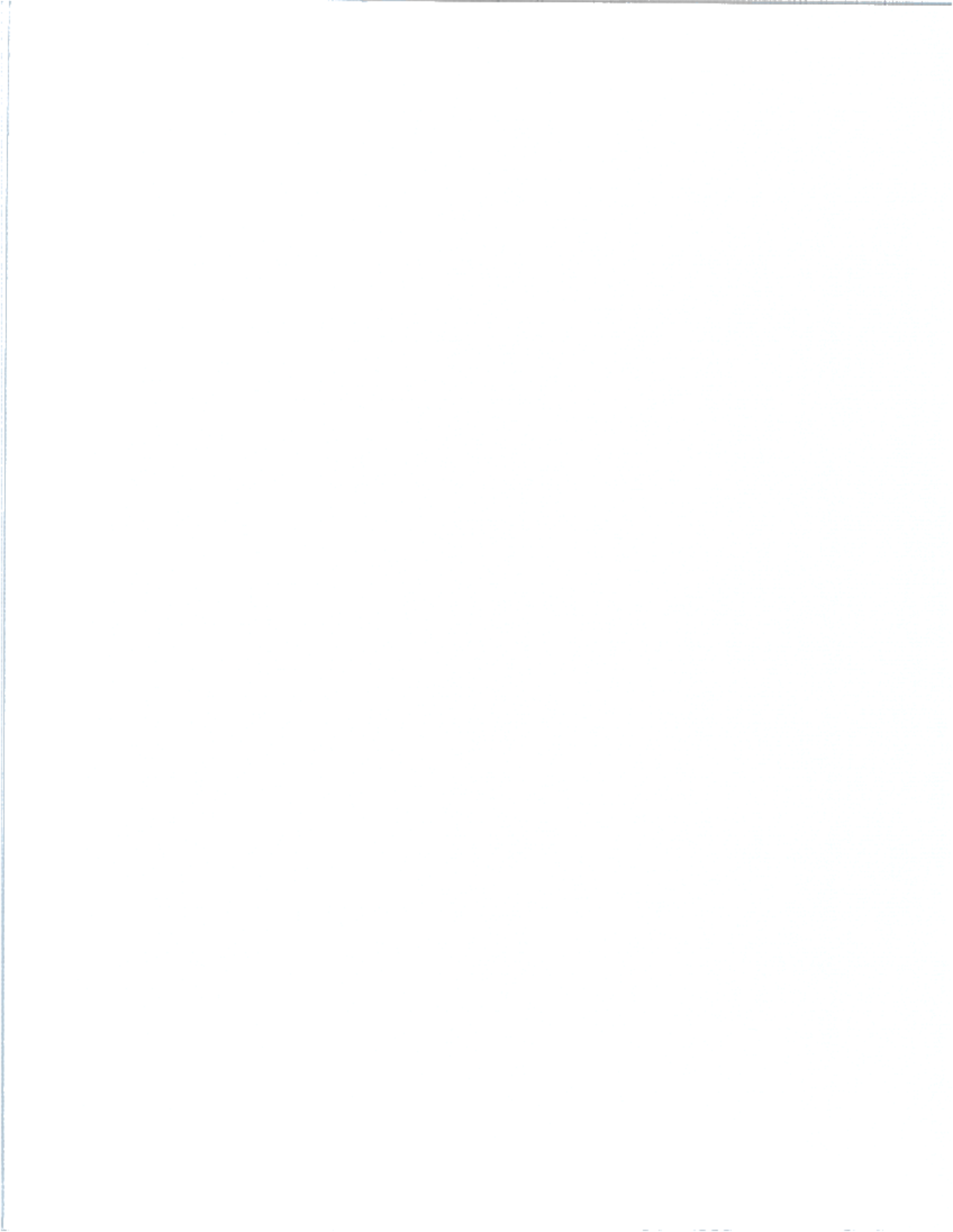
12. DRIVER'S NAME (Last, first, middle)		13. DRIVER'S LICENSE NUMBER/STATE/LIMITATIONS			
14a. DRIVER'S WORK ADDRESS				14b. WORK TELEPHONE NUMBER ()	
15a. DRIVER'S HOME ADDRESS				15b. HOME TELEPHONE NUMBER ()	
16. DESCRIBE VEHICLE DAMAGE				17. ESTIMATED REPAIR COST \$	
18. YEAR OF VEHICLE	19. MAKE OF VEHICLE	20. MODEL OF VEHICLE		21. TAG NUMBER AND STATE	
22a. DRIVER'S INSURANCE COMPANY NAME AND ADDRESS				22b. POLICY NUMBER	
				22c. TELEPHONE NUMBER ()	
23. VEHICLE IS <input type="checkbox"/> CO-OWNED <input type="checkbox"/> RENTAL <input type="checkbox"/> LEASED <input type="checkbox"/> PRIVATELY OWNED		24a. OWNER'S NAME(S) (Last, first, middle)		24b. TELEPHONE NUMBER ()	
25. OWNER'S ADDRESS(ES)					

SECTION III - KILLED OR INJURED (Use Section VII if additional space is needed.)

26. NAME (Last, first, middle)		27. SEX	28. DATE OF BIRTH		
29. ADDRESS					
30. MARK "X" IN TWO APPROPRIATE BOXES <input type="checkbox"/> KILLED <input type="checkbox"/> DRIVER <input type="checkbox"/> PASSENGER <input type="checkbox"/> INJURED <input type="checkbox"/> HELPER <input type="checkbox"/> PEDESTRIAN		31. IN WHICH VEHICLE <input type="checkbox"/> FED <input type="checkbox"/> OTHER (2)	32. LOCATION IN VEHICLE	33. FIRST AID GIVEN BY	
34. TRANSPORTED BY		35. TRANSPORTED TO			

36. NAME (Last, first, middle)		37. SEX	38. DATE OF BIRTH		
39. ADDRESS					
40. MARK "X" IN TWO APPROPRIATE BOXES <input type="checkbox"/> KILLED <input type="checkbox"/> DRIVER <input type="checkbox"/> PASSENGER <input type="checkbox"/> INJURED <input type="checkbox"/> HELPER <input type="checkbox"/> PEDESTRIAN		41. IN WHICH VEHICLE <input type="checkbox"/> FED <input type="checkbox"/> OTHER (2)	42. LOCATION IN VEHICLE	43. FIRST AID GIVEN BY	
44. TRANSPORTED BY		45. TRANSPORTED TO			

46. Pedestrian	a. NAME OF STREET OR HIGHWAY	b. DIRECTION OF PEDESTRIAN (SW corner to NE corner, etc.)	
		FROM	TO
	c. DESCRIBE WHAT PEDESTRIAN WAS DOING AT TIME OF ACCIDENT (Crossing intersection with signal, against signal, diagonally, in roadway playing, walking, etc.)		



Accident Witness Statement

(To be completed by accident witness)

Injured Employee's name: _____
Last First Middle

Name of Witness: _____
Last First Middle

Job title of Witness: _____ How long employed here? _____

Home address of witness: _____

City: _____ State: _____ Zip Code: _____

Location of accident: _____
Address/Name of building Area (bathroom, etc.)

Date of accident: _____ Time of accident: _____

Describe fully how accident occurred: _____

(continue on other side, if necessary)

Describe bodily injury sustained (be specific about body part(s) affected): _____

Recommendation on how to prevent this accident from recurring: _____

(continue on other side, if necessary)

Name of Supervisor: _____
Last First Middle

Signature of Witness: _____ Date: _____

Supervisor's Accident Investigation

(To be completed by the employee's supervisor or other responsible administrative official)

Location where accident occurred		Employer's Premises: Yes <input type="checkbox"/> No <input type="checkbox"/>		Date of accident or illness
		Job site: Yes <input type="checkbox"/> No <input type="checkbox"/>		
Who was injured?		<input type="checkbox"/> Employee <input type="checkbox"/> Non-Employee		Time of accident a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>
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 was damaged?			Property owned by	
What was employee doing when injury/illness occurred? What machine or tool? What operation?				
How did injury/illness occur? List all objects and substances involved.				
Part of body affected		Any prior physical defects? If so, what? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Nature and extent of injury/illness and property damaged (be specific).				

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

- | | | |
|--|--|--|
| <input type="checkbox"/> Improper instruction | <input type="checkbox"/> Failure to lockout | <input type="checkbox"/> Unsafe arrangement or process |
| <input type="checkbox"/> Lack of training or skill | <input type="checkbox"/> Unsafe position | <input type="checkbox"/> Poor ventilation |
| <input type="checkbox"/> Operating without authority | <input type="checkbox"/> Improper dress | <input type="checkbox"/> Improper guarding |
| <input type="checkbox"/> Horseplay | <input type="checkbox"/> Improper protective equipment | <input type="checkbox"/> Improper maintenance |
| <input type="checkbox"/> Physical or mental impairment | <input type="checkbox"/> Unsafe equipment | <input type="checkbox"/> Inoperative safety device |
| <input type="checkbox"/> Failure to secure | <input type="checkbox"/> Poor housekeeping | <input type="checkbox"/> Other _____ |

Supervisor's corrective action to insure this type of accident does not reoccur: _____

Was employee retrained 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 ___

Supervisor's name _____

Supervisor's signature _____

Date _____