

Resolution No.: 18-472  
Introduced: May 10, 2016  
Adopted: May 10, 2016

**COUNTY COUNCIL  
FOR MONTGOMERY COUNTY MARYLAND**

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Lead Sponsor: County Council

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**SUBJECT:** Executive Regulation 1-16, Repeal of Executive Regulation 29-90, Workers' Compensation Claims

**Background**

1. Executive Regulation 29-90 established a uniform method of reporting and filing claims for on-duty injuries and occupational diseases by Fire and Rescue Corporation volunteers and employees of the Montgomery County Department of Fire and Rescue Services. The Fire Chief has prepared a new Montgomery County Fire and Rescue Service (MCFRS) policy, *Workers' Compensation Claims*, to replace this regulation, which pre-dates the current structure of the MCFRS. As a result, Executive Regulation 29-90 is obsolete and conflicts with the current structure of the MCFRS.
2. On March 24, 2016, the County Council received the Executive's request to repeal Executive Regulation 29-90, *Workers' Compensation Claims*. The Fire and Emergency Services Commission also approved the repeal of this regulation.
3. Section 2A-15(f)(1) of the County Code provides that to repeal an adopted regulation, an issuer must use the procedure under which the regulation was adopted. Executive Regulation 29-90 was adopted under Method (2). Under Method (2), if the Council does not approve or disapprove a regulation within 60 days after the Council receives the regulation, it is automatically approved and takes effect the day after the deadline for approval or a later date specified in the regulation.

**Action**

The County Council for Montgomery County, Maryland approves the following resolution:

Executive Regulation 1-16 is approved, repealing Executive Regulation 29-90, *Workers' Compensation Claims*.

This is a correct copy of Council action.



Linda M. Lauer, Clerk of the Council



# MONTGOMERY COUNTY EXECUTIVE REGULATION

Offices of the County Executive • 101 Monroe Street • Rockville, Maryland 20850

Subject	WORKERS' COMPENSATION CLAIMS	Number	1-16
Originating Department	MONTGOMERY COUNTY FIRE AND RESCUE SERVICE	Effective Date	May 10, 2016

## MONTGOMERY COUNTY FIRE AND RESCUE SERVICE REGULATION ON:

### REPEAL OF EXECUTIVE REGULATION #29-90, WORKERS' COMPENSATION CLAIMS

Issued by: Montgomery County Fire and Rescue Commission  
 Regulation No. 29-90  
 Authority: Code Section 21-4B(e) (3)  
 Supersedes: No prior regulation  
 Council Review: Method (2) under Code Section 2A-15  
 Register Vol. 33, No. 1

Effective Date: May 10, 2016  
 Comment Deadline: January 31, 2016

**SUMMARY:** Executive Regulation No. 29-90, Workers' Compensation Claims is being repealed because it is outdated and obsolete.

**ADDRESS:** George Giebel, Montgomery County Fire and Rescue Service, Office of the Fire Chief, 100 Edison Park Drive, 2<sup>nd</sup> Floor, Gaithersburg, Maryland 20878

**BACKGROUND:** The Workers' Compensation Claims Regulation 29-90 adopted on January 29, 1991, established a procedure for use by all fire and rescue Corporations and the Department of Fire and Rescue Services to report on-duty injuries and occupational diseases sustained by volunteer personnel and Corporation employees. The Fire Chief has determined that replacing the Executive Regulation with an updated policy would enhance the ability to amend or change requirements in the policy in a more effective manner. The proposed Workers' Compensation Policy brings the policy into compliance with all current Maryland State Laws. The proposed policy establishes procedures for all Montgomery County Fire and Rescue personnel to report on-duty injuries and occupational diseases. All MCFRS Workers' Compensation claims must be reported through the Montgomery County Self-Insurance Program.



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Subject <b>WORKERS' COMPENSATION CLAIMS</b>	Number 1-16
Originating Department <b>MONTGOMERY COUNTY FIRE AND RESCUE SERVICE</b>	Effective Date

[Sec. 1. Purpose.

To establish guidelines for the completion and submission of Workers' Compensation claims.

Sec. 2. Applicability.

All employees and volunteers of the Corporations and volunteer personnel of the Department.

Sec. 3. Definitions.

- (a) Claims Administrator. For primary insurance, an independent adjuster under contract to the Division of Risk Management, for the Montgomery County Self-Insurance Program. For secondary insurance, an insurance vendor pursuant to a policy administered by the Montgomery County Fire Board.
- (b) Corporation. A fire or rescue Corporation established in the County, authorized to provide fire, rescue, or emergency medical services.
- (c) Department. Department of Fire and Rescue Services.
- (d) Injury. An accidental injury arising out of and in the course of employment or volunteer service with a Corporation or the Department, as defined by the Maryland Workers' Compensation statute and as interpreted by Maryland case law.
- (e) Insurance Administrator. For primary insurance coverage, the Insurance Administrator is the Montgomery County Division of Risk Management, Department of Finance, under the Montgomery County Self-Insurance Program. For secondary coverage, the Insurance Administrator is the Montgomery County Fire Board.
- (f) Occupational Disease. An ailment, disorder, or illness which is the expectable result of working under conditions inherent in employment or volunteer service with a Corporation or the Department, which may arise out of and in the course of employment or volunteer service, as defined by the Maryland Workers' Compensation statute and as interpreted by Maryland case law.



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- (g) On-duty. Any time that personnel are acting in an official capacity on the scene of an emergency incident in Montgomery County, Maryland, on a dispatched Mutual Aid assignment outside of the County, or are enroute to or returning from any fire or rescue incident or official activity.
- (h) Personnel. Volunteer members and employees of the Corporations or volunteer personnel with the Department.
- (i) Responsible Corporate Authority. The Corporation Fire Chief or designee.
- (j) Supervisor. The Officer-in-Charge of personnel at any given time, as designated by the Integrated Emergency Command Structure.

#### Sec. 4. Policy.

It is the policy of Montgomery County that personnel who are unable to work in their current employment due to sustaining an injury or contracting an occupational disease as a result of having provided volunteer fire, rescue, or emergency medical services on behalf of Montgomery County, will be compensated for lost wages in accordance with Maryland's Workers' Compensation statute.

#### Sec. 5. Procedure.

- (a) All personnel must immediately report to their supervisor any injury or occupational disease or suspected injury or occupational disease sustained while on duty. Subsequently:
  - (1) The supervisor must complete a Supervisor's Incident Investigation Report, a First Report of Injury (Appendices (A) and (B)), and all other applicable forms within his or her area of responsibility. All reports must be submitted to the responsible corporate authority within 48 hours of the injury or onset of occupational disease.



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- (2) the responsible corporate authority must submit the reports to the primary Insurance Administrator within 10 days of the occurrence of the injury or onset of the occupational disease. Copies of the reports must also be sent to the affected individual and placed in his or her personal file.
- (b) If the primary Claims Administrator has reviewed the First Report of Injury and has found an injury or occupational disease to be compensable, the primary Claims Administrator will process all related bills for payment. Lost wages will be paid by the primary Claims Administrator, within the limits established by the Workers' Compensation Commission. Secondary coverage for volunteer members, up to the limits of the policy, will be considered by the secondary Insurance Administrator through a separate claim. This secondary coverage does not apply to employees of the Department.
- (c) If the primary Claims Administrator has reviewed the First Report of Injury for a volunteer member and has determined that a claim is not compensable, copies of the documentation must be sent to the secondary Insurance Administrator for consideration. In addition, affected individual may request a hearing before the State Worker's Compensation Commission for a determination on the compensability of the claim, or any other related issue.
- (d) The following requirements apply to Corporation employees:
- (1) Corporation employees who lose time from work due to injuries or occupational disease will be charged Sick Leave in accordance with the Fire and Rescue Corporation Personnel Regulations until the Insurance Administrator, the Claims Administrator, or the Workers' Compensation Commission rules on the compensability of the claim. Department employees acting as volunteers also will be charged Sick Leave if the Claims Administrator discontinues benefits before the employee returns to work.



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(2) If the Claims Administrator has reviewed the First Report of Injury and has found the injury or occupational disease of a Corporation employee to be compensable, the individual will be recredited with any Sick Leave charged and placed on disability leave during said period. To recredit sick leave, a memorandum must be sent to the Administration Section, Division of Risk Management, specifying the dates and number of days, the number of hours of each day, and the total number of hours charged. Medical documentation to substantiate the amount of time off must also be attached.

(3) A Corporation employee who has been awarded a permanent partial disability determination from the Workers' Compensation Commission will be charged Sick Leave for subsequent visits to his or her physician to receive treatment for the compensated injury or occupational disease.

(e) Personnel who have sustained an injury or contracted an occupational disease must complete and submit a Worker's Compensation Commission Form MP-C1 (Appendix C) to the Workers' Compensation Commission if their recovery requires more than three days off firefighting, rescue, or emergency medical services duty, or off their normal employment. Personnel may file this claim up to two years from the date of filing a First Report of Injury with the Insurance Administrator.

(f) Personnel who were unable to perform their volunteer duties as a firefighter, rescuer, or provider of emergency medical services as a result of having sustained an injury or having contracted an occupational disease must present certification from their private physician to the responsible corporate authority, attesting that they are fit for duty as a firefighter, rescuer, or emergency medical services provider, before returning to duty following recovery from any job-related injury or occupational disease. If the disability lasts longer than 3 days, they must also obtain certification from the Occupational Medical Section by submitting to a medical examination and providing medical documentation to the Occupational Medical Section and the Corporation or the Department, as applicable, certifying that they are fit for duty as a firefighter, rescuer, or emergency medical services provider.



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## Sec. 6. Responsibility.

- (a) Personnel who are injured or contract an occupational disease, or suspect that they may have been injured or may have contracted an occupational disease while on duty, must report the incident to their supervisor, regardless of how slight the injury or occupational disease may seem. They must also complete and submit the required reports.
- (b) Personnel who sustain an injury or contract an occupational disease must submit relevant information regarding their medical condition to the responsible corporate authority of the Corporation or the Director of the Department, as appropriate.
- (c) Personnel who sustain an injury or contract an occupational disease must inform their physician and/or hospital to send bills directly to the primary Claims Administrator for processing, unless otherwise directed.
- (d) When notified of any injury or occupational disease, or suspected injury or occupational disease, the supervisor must complete the required reports.
  - (1) The supervisor should determine if contributory factors led to the injury or occupational disease and note this on the reports.
  - (2) The supervisor should also note in his or her report whether there were any witnesses to the injury or onset of occupational disease.
  - (3) Department supervisors are required to follow this procedure in completing documentation on volunteer personnel.



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- (e) The Corporations and the Department must submit to the Insurance Administrator any First Report of Injury received on behalf of their respective personnel, regardless of how or where the injury or occupational disease may have occurred.
- (f) All completed reports must be forwarded to the responsible corporate authority of the Corporation, or the Director of the Department, for their respective personnel.
- (g) The responsible corporate authority is not responsible for initiating the claims process. However, the responsible corporate authority must:
- (1) review all claims of injuries and occupational diseases, adding information as necessary;
  - (2) ensure that reports are completed accurately and legibly; and,
  - (3) forward all documentation to the Insurance Administrator.
- (h) The Corporations and the Department must also notify the Insurance Administrator in writing of any report received and submitted which, in their opinion, is not the responsibility of the Corporation, the Department, or the County.

## Sec. 7. Severability.

If a court of final appeal holds that any part of this regulation is invalid, that ruling does not affect the validity of other parts of the regulation.

## Sec. 8 Effective Date.

This regulation is effective 30 days after Council adoption or 90 days after Council receipt if the Council takes no action within 60 days of its receipt.



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Subject

WORKERS' COMPENSATION CLAIMS

Number

1-16

Originating Department

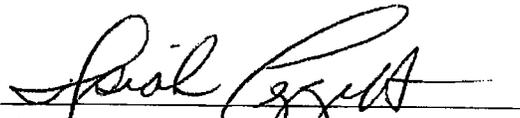
MONTGOMERY COUNTY FIRE AND RESCUE SERVICE

Effective Date

Sec. 9. Appendices.

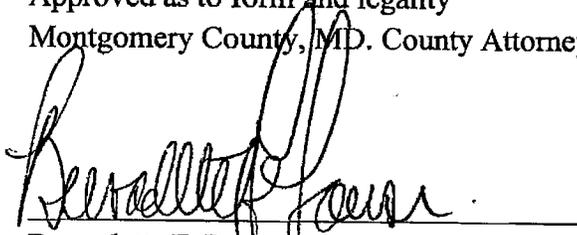
- (A) Supervisor's Incident Investigation Report
- (B) Employee's First Report of Injury
- (C) Workers' Compensation Commission Form MP-CI]

Attest:]

  
 County Executive Isiah Leggett

March 24, 2016  
 Date

Approved as to form and legality  
 Montgomery County, MD. County Attorney's Office

  
 Bernadette F. Lamson  
 Associate County Attorney

12/14/2015  
 Date



<b>(E) GENDER OF EMPLOYEE</b>		<b>(F) EMPLOYEE STATUS</b>	
1007- Male	1008- Female	1009- Full-time 1010- Part-time 1011- Temporary (FT or PT)	1012- Volunteer 1013- Non-County Employee

**SAFETY SECTION USE ONLY**

<b>(G) LENGTH OF TIME PERFORMING THIS JOB</b>		<b>(H) NUMBER OF HOURS INTO SHIFT WHEN INCIDENT OCCURRED</b>	
(Round to the nearest whole number)	1017 10-11 Months	1021 11-15 Years	(Round to the nearest whole number)
1014 0-3 Months	1018 1-2 Years	1022 16-20 Years	1027 6-7 Hours
1015 4-6 Months	1019 3-5 Years	1023 Over 20 Years	1028 8-9 Hours
1016 7-9 Months	1020 6-10 Years		1029 10 Hrs or more
			1030 Unknown

<b>(I) TASK BEING PERFORMED AT TIME OF INCIDENT</b>		
1031- Construction/Fabrication/Installation/Demolition	1038- Operating Machinery (Including Heavy Equipment)	1044- Physical Fitness Activities/Recreation (Team Sports)
1032- Housekeeping	1039- Materials Handling Operations (Including the Operation of Forklifts)	1045- Service Activities, Other
1033- Inspection/Investigation/Testing	1040- Office Tasks	1046- Unauthorized Task
1034- Maintenance (Repair) of Building, Building Equipment, or Grounds	1041- Operating/Riding in/on a Motor Vehicle (Not Responding/Returning)	1047- Multiple Tasks or Unknown (Use for Illnesses and Exposures Only, When Applicable)
1035- Maintenance/Repair/Refueling Highway Vehicle	1042- Operating/Using Hand/Power Tools	1048- Other, Not Listed Above; Specify Below:
1036- Maintenance/Repair of Road/Highway	1043- Physical Fitness Activities/Recreation/Physical Testing (Individual Sports)	
1037- Maintenance/Repair, Other		
2075- Moving to/from Location on Foot		
<b>TASKS SPECIFIC TO PUBLIC SAFETY</b>		
1049- Controlling Suspect/Prisoner/Patient	1053- Haz-Mat Incident	1057- Responding to an Emergency
1050- Controlling/Capturing an Animal	1054- Non-Emergency Operations at the Scene of an Incident	1058- Returning from an Emergency
1051- Fighting a Fire	1055- Pursuing a Suspect	1059- Training Evolution (Firefighting - See #1052)
1052- Firefighting Drill (Live)	1056- Rescue Call	

**OCCUPATIONAL INJURY/ILLNESS/EXPOSURE INFORMATION**

<b>(J) INCIDENT CLASSIFICATION</b>		
1060- Caught In, Under, or Between	1070- Exposure to Infectious Substances	1078- Psychological Trauma
1061- Caught or Trapped in an Enclosed Area	1071- Fall from Vehicle/Apparatus	1079- Repetition of Pressure/Motion (ie. Noise, CTS)
1062- Contact with Electric Current	1072- Fall into Floor Opening, Open Shaft	1080- Rubbed or Abraded
1063- Contact with Foreign Matter (ie. Dirt in Eyes)	1073- Fall on Same Level	1081- Slip/Trip (Without Fall)
1064- Contact with Sharp Object	1074- Fall to Different Level	1082- Struck Against
1065- Contact with Temperature Extremes (Burns, etc.)	1075- Gunshot	1083- Struck By
1066- Exposure to Environmental Cold	1076- Physical Overexertion/Overextension	1084- Other, Not Listed Above; Specify Below:
1067- Exposure to Environmental Heat	1077- Public Transportation Accident (in which Injured was a Passenger)	
1068- Exposure to Fire Products		
1069- Exposure to Hazardous Substances/Chemicals		

<b>(K) BODILY ACTIVITY AT TIME OF INCIDENT</b>				
1085- Bending	1089- Jumping/Landing	1093- Mounting/Dismounting Vehicle or Equipment	1096- Reaching or Stretching	1100- Standing
1086- Climbing	1090- Kneeling	1094- Pulling	1097- Riding	1101- Twisting
1087- Crawling	1091- Lifting	1095- Pushing	1098- Running	1102- Walking
1088- Driving	1092- Lying Down		1099- Sitting	1103- Multiple Actions
				1104- Unknown

<b>(L) NATURE OF INJURY/ILLNESS</b>			
1105- Abrasion	1113- Concussion/Unconscious	1121- Freezing/Frostbite/Hypothermia	1129- Poisoning, Systemic
1106- Amputation	1114- Contagious/Infectious Disease	1122- Heat Stroke/Stress	1130- Psychological Disorder
1107- Bite, Animal, Human or Insect	1115- Cut/Scratch Laceration/Puncture	1123- Hernia/Rupture	1131- Radiation Effects
1108- Blunt/Penetrating Trauma	1116- Dislocation	1124- Impaired Sensory Perception	1132- Separation/Avulsion
1109- Bruise/Contusion	1117- Electric Shock	1125- Inflammation	1133- Sprain/Strain
1110- Burn (Chemical)	1118- Fatality	1126- Injection	1134- Suffocation/Asphyxiation
1111- Burn (Electrical)	1119- Foreign Substance	1127- Irritation	1135- Other Injury Nature; Specify Below:
1112- Burn or Scald (Heat)	1120- Fracture	1128- Muscle Spasm	

<b>(M) BODY PART MOST AFFECTED (SELECT ONE FROM EACH BOX BELOW)</b>				
1136- Right	HEAD/NECK	UPPER EXTREMITIES	1156- Back, Lower	1165- Leg, Lower
1137- Left	1140- Ear(s)/Hearing	1148- Arm, Upper or Lower	1157- Chest	1166- Toe(s)
1138- Both	1141- Eye(s)/Sight	1149- Elbow	1158- Groin/Genitalia	
1139- Not Applicable	1142- Face	1150- Finger(s)/Thumb	1159- Hip/Buttock	BODY SYSTEMS
	1143- Jaw	1151- Hand	1160- Shoulder	1167- Cardiovascular System
	1144- Mouth/Teeth	1152- Wrist		1168- Digestive System
	1145- Nose		LOWER EXTREMITIES	1169- Nervous System
	1146- Scalp/Skull	TRUNK	1161- Ankle	1170- Respiratory System
	1147- Neck/Throat	1153- Abdomen	1162- Foot	1171- Skin
		1154- Back, Upper	1163- Knee	1172- Entire Body
		1155- Back, Middle	1164- Leg, Upper	(Use for Some Illnesses and Exposures)

**(N) SOURCE OF INJURY, ILLNESS, OR EXPOSURE**

Indicate Below the Specific Object, Substance or Environmental Condition which Caused the Injury, Illness or Exposure

**D CONTRIBUTING CAUSES OF THE INCIDENT: HAZARDOUS CONDITIONS**

1173- Actions of Others	1183- Maintenance	<b>SAFETY SECTION USE ONLY</b>
1174- Assembly or Design Flaws	1184- Natural Environment/Weather	
1175- Assignment of Personnel/Work Shifts	1185- Noise	
1176- Atmosphere/Ventilation	1186- Person Who is Violent/Combative/ Intoxicated/Otherwise Affected	
1177- Congestion/Housekeeping	1187- Sharp or Protruding (Not for Knives, Blades, or Other Intentionally Sharp Objects)	
1178- Dress/Apparel	1188- Slippery (Not Walking/Working Surfaces)	
1179- Fire Hazard	1189- Storing/Stacking/Securing/Shoring	
1180- Guard or Safety Device	1190- Tool/Equipment Damage	
1181- Illumination/Glare		
1182- Labeling/Warning		

**P CONTRIBUTING CAUSES OF THE INCIDENT: UNSAFE ACTS**

1194- Acts Relating to Hazardous Conditions	2000- Horseplay	2006- Speed of Operation
1195- Alteration of Safety Devices	2001- Instructing/Warning	2007- Use of Tools/Equipment/Furnishings
1196- Attention to Footings or Surroundings	2002- Loading	2008- Training for Job/Task
1197- Wearing of Personal Attire	2003- Method or Procedure	2009- Other Unsafe Act Not Listed; Specify Below:
1198- Control of Suspect/Prisoner/Patient	2004- Related to the Use of Personal Protective Equipment	
1199- Use of Hands or Body Parts	2005- Related to Proper Body Positioning or Posture	

**Q INJURY/ILLNESS/EXPOSURE TREATMENT/OUTCOME**

2010 On-the-Job Fatality	2012 Immediate First Aid or Immediate Medical Treatment Administered Only Cases <i>WITH</i> -No Restriction of Work Activities or Bodily Motion -No Loss of Consciousness -No Assignment to Another Job Position -No Fractures
2011 Incident involving any of the following: -Occupational Illness -Medical Treatment Administered beyond Immediate or First Aid -Restriction of Work Activities (including time away from work) -Restriction of Bodily Motion Inhibiting Ability to Perform Job -Assignment to Another Job Position -Fracture(s) -Loss of Consciousness	2013 No Treatment Required at this Time

Where work activities have been restricted, or employee has been assigned to another position as a result of this incident, enter date of first full scheduled workshift affected: \_\_\_\_\_

DO NOT INCLUDE THE DAY OF THE INCIDENT. \_\_\_\_\_

Has Medical Documentation of Incident Been Attached to this Report?  
Yes \_\_\_\_\_  
No Reason: \_\_\_\_\_

Employee's Comments and Corrective Recommendations: \_\_\_\_\_

Supervisor's Comments: \_\_\_\_\_

Supervisor: What steps have you taken to prevent a recurrence: (Check Items Completed/Implemented)

- Equipment/Environment \_\_\_\_\_  Policies/Procedures \_\_\_\_\_
- Education/Training \_\_\_\_\_  Other \_\_\_\_\_

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_ Supervisor Signature \_\_\_\_\_ Date \_\_\_\_\_

**MOTOR VEHICLE INCIDENT INFORMATION**

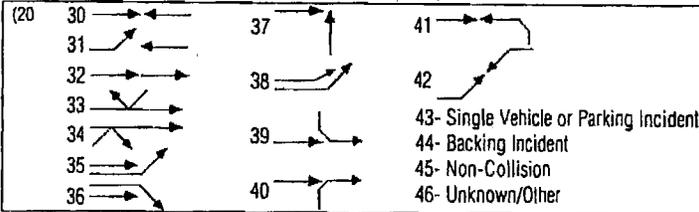
**R VEHICLE TYPE**

- 2014- Automobile
- 2015- Bus
- 2016- Light Truck/Apparatus/Ambulance
- 2017- Heavy Truck/Apparatus
- 2018- Heavy Equipment
- 2019- Motorcycle
- 2020- Scooter/Cart

**S GENERAL CLASSIFICATION**

- 2021- Non-Collision Incident
- 2022- County Vehicle Parked - Other Vehicle Moving
- 2023- Other Vehicle Parked - County Vehicle Moving
- NON-PARKING INCIDENTS
- 2024- Involving a Non-Vehicular Fixed Object
- 2025- Involving a Pedestrian, Animal, or Other
- 2026- County Vehicle in Transit - No Other Involved
- 2027- County Vehicle in Transit - Other(s) Involved
- 2028- Involving Another County Vehicle
- Other County Vehicle Number \_\_\_\_\_
- 2029- Other Type Incident Not Listed Above

**T TYPE OF COLLISION (Circle The Best Diagram)**



**U COUNTY VEHICLE DAMAGE**

Indicate Severity.

- 2047- No Damage to County Vehicle
- 2048- Minor Damage Only
- 2049- Functional Damage
- 2050- Disabling Damage
- 2051- Unknown

Circle Number to Indicate Area of Primary Damage

(20) 52 55 58

REAR 53 56 59 FRONT

54 57 60

**V ROAD SURFACE**

- 2061- Wet
- 2062- Dry
- 2063- Snow or Ice
- 2064- Mud or Other
- 2065- Unknown

**W WEATHER CONDITIONS**

- 2066- Clear or Cloudy Sky (No Precipitation)
- 2067- Foggy
- 2068- Raining
- 2069- Snowing
- 2070- Other/Unknown

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_ Supervisor Signature \_\_\_\_\_ Date \_\_\_\_\_

DATE OF LAST DDT \_\_\_\_\_

2071 RECORDABLE 2072 NON-RECORDABLE 2073 PREVENTABLE 2074 NON-PREVENTABLE

DATE \_\_\_\_\_ INIT \_\_\_\_\_

A copy shall be mailed to the Division of Labor and Industry, 203 E. Baltimore Street, Baltimore, Maryland 21202

STANDARD FORM FOR EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

Complete and send immediately to WORKMENS COMPENSATION COMMISSION 102 E. LEXINGTON STREET, BALTIMORE, MD. 21202

PLEASE PRINT OR TYPE

- 1. Employer Name
2. Mail Address

- CHECK MONTGOMERY COUNTY GOVERNMENT
MONTGOMERY COUNTY PUBLIC SCHOOLS
MONTGOMERY COLLEGE
OTHER

DO NOT WRITE IN THIS SPACE
WCC CLAIM #
DOCTOR'S REPORT Yes No
SOUNDEX #
Federal Employer Identification Number (FBN)
LARS LOCA CODE

3. Nature of Business (Manufacturing shoes, retailing men's clothes, trucking, etc.)
3a. Insured By MONTGOMERY COUNTY MARYLAND INTERAGENCY SELF INSURANCE FUND

4. TIME AND PLACE Location of plant or place where accident or disease occurred
Department
State if employer's premises Yes No

5. Date of injury 19 Day of week
5a. Hour employee started work AM PM
6. Was injured paid for one-half or more for day of injury? Yes No

7. Date disability began 19 A.M. P.M.
When did you or foreman first know of injury?
Name of foreman Phone

8. INJURED PERSON Name of injured (First - Middle - Last Name)
Social Security No. Area Code Phone

9. Address (No. and Street) (City or Town) (State) (Zip)

10. Check Married Single Widowed Divorced Male Female
11. Nationality Speak English Yes No

12. Age Did you have an ILE employment certificate or permit? Yes No
(a) Occupation when injured
(b) Department where regularly employed

13. Was this his or her regular occupation? Yes No (If not, state in what department or branch of work regularly employed)
Location of Accident

14. How long employed by you? (a) Pieceworker Timeworker
15. No. of hours worked per day per week No. of days worked per week

16. Wages \$ per hour, or \$ per day, or \$ per week
(If paid on other than a time basis, such as piece work or commission - Average weekly earnings \$

17. If board, lodging, tips, fuel or other advantages were furnished in addition to wages, give estimated value per day, week or month \$
18a. Nature of injury or occupational disease Part of body Type of injury

18b. How did accident or occupational disease occur? (Describe fully-use back of form if necessary . . . reverse carbon when using back of form)

18c. What was employee doing when injured? (Be specific. When using tools or equipment, what was he doing with them?)
19. Probable length of disability

20. Name of object which injured employee (if machine: name, model, serial number)
21. Kind of machine power

22. Part of machine on which accident occurred
23. (a) Was safety appliance or regulation provided? Yes No (b) Was it in use at time? Yes No
24. Was accident caused by injured's failure to use or observe safety appliance or regulation? Yes No

25. Has injured returned to work? Yes No If so, date and hour
a. At what wage \$
b. At what occupation?

26. Name and address of physician
27. Name and address of hospital

28. FATAL CASES - Has injured died? Yes No If yes give date of death

Date of this report Firm Name Prepared by

# EMPLOYEE'S CLAIM

Claim No. \_\_\_\_\_

**WORKERS' COMPENSATION COMMISSION**  
 6 NORTH LIBERTY STREET  
 BALTIMORE, MARYLAND 21201-3785  
 BALTIMORE PHONE (301) 333-4700  
 TOLL FREE PHONE 1-800-482-6479 IN MARYLAND  
 BALTIMORE TTY FOR DEAF 383-7555

Insurance Co. and Code No. \_\_\_\_\_

Commission has received	Yes	No
Employer's Report	<input type="checkbox"/>	<input type="checkbox"/>
Doctor's Report	<input type="checkbox"/>	<input type="checkbox"/>

1. Claim No. \_\_\_\_\_  
 1. Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_ 2. Phone No. \_\_\_\_\_  
**DO NOT WRITE IN THIS SPACE BELOW**

3. Home Address \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ 4. INS CO 1 \_\_\_\_\_

5. Social Security Number \_\_\_\_\_ 6. Sex \_\_\_\_\_ 7. Date of Birth \_\_\_\_\_ 8. Single Married   9. What was your regular work? \_\_\_\_\_ 10. ATTY \_\_\_\_\_

11. Gross wages or earnings (including Tips, Bonus, Overtime, Allowances) at time of accident \_\_\_\_\_ Per week \_\_\_\_\_ 12. Were you paid full wages for the day of the accident? Yes  No  13. What was your work when injured? \_\_\_\_\_ 14. INS CO 2 \_\_\_\_\_

15. Full and correct business name of your employer \_\_\_\_\_ 16. Nature of Employer's business (type business, work done, kind of trade, etc.) \_\_\_\_\_ 17. ATTY \_\_\_\_\_

18. Complete address \_\_\_\_\_ 19. Location where accident occurred \_\_\_\_\_ 20. EMPLOYER \_\_\_\_\_

21. City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ 22. Name of Foreman \_\_\_\_\_ Have you given him/her notice of injury? Yes  No  23. EMP. ATTY. \_\_\_\_\_

24. Employer phone no. \_\_\_\_\_ 25. Give date of first day you could not work because of injury or disease even if it was a day you normally do not work. \_\_\_\_\_ 26. CLMT. ATTY \_\_\_\_\_

27. Date of Accident: \_\_\_\_\_ month \_\_\_\_\_ day \_\_\_\_\_ year 19 \_\_\_\_\_ at \_\_\_\_\_ am  pm  28. If occupational disease, give date of disablement. \_\_\_\_\_ 29. CAUSE \_\_\_\_\_

30. Describe how accidental injury occurred \_\_\_\_\_ OR describe how occupational disease occurred \_\_\_\_\_ 31. BODY LOC. \_\_\_\_\_  
 32. CLASS CODE \_\_\_\_\_  
 33. N. OF L. \_\_\_\_\_  
 34. INDUSTRY \_\_\_\_\_

35. What member of your body was injured? \_\_\_\_\_ 36. Has injury resulted in amputation Yes  No  If yes, describe loss \_\_\_\_\_ 37. M.I. \_\_\_\_\_

38. Do you request your employer to provide medical care? Yes  No  39. Has he done so? Yes  No  40. Have you returned to work? If "Yes", on what date did you return? Yes  No  41. ALL EMP \_\_\_\_\_

42. Name and Address of Attending Physician: \_\_\_\_\_ 43. If an Attorney is representing you in this case give his name, address and phone no. \_\_\_\_\_ 44. O.D. \_\_\_\_\_

45. Are you in a hospital? If "Yes", give name and address of hospital: \_\_\_\_\_  No  46. MEDICAL \_\_\_\_\_

47. Is this the only Workers' Compensation Claim you have filed for this Accident or Occupational Disease? Yes  No  If "No", give claim no. \_\_\_\_\_ 48. HEALTH \_\_\_\_\_

49. Health insurance used, give name of insurance Co. \_\_\_\_\_ 50. \_\_\_\_\_

51. I hereby make 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, and in support of it I make the foregoing statement of facts.

**KEEP 2ND PAGE FOR YOUR RECORD — READ REVERSE BEFORE SIGNING**

52. \_\_\_\_\_ 19 \_\_\_\_\_ SIGNATURE \_\_\_\_\_ EMPLOYEE FULL NAME \_\_\_\_\_

**DO NOT WRITE IN THIS SPACE**

**ATTENTION: FOR EMPLOYER AND INSURER INFORMATION ONLY**

Consideration Date: Unless the compensability of this claim is contested by the filing of issues with the Commission on or before \_\_\_\_\_ an appropriate award will be passed.

Correct Name of Employer according to Commission Records (if different from Para. 12)

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**IMPORTANT:** It is the responsibility of the employee to provide this information. Always include claim number on any correspondence.

### DISCLOSURE PURSUANT TO EXECUTIVE ORDER 01.01.1983.18

1. The personal information requested on this form is intended to be used in processing your claim for benefits under worker's compensation laws.
2. Failure to provide the information requested may result in delay of your claim for benefits.
3. You have a right to inspect, amend and correct the information provided on this form pursuant to Sections 1-5 of Article 76A of the Maryland Annotated Code.
4. This form will be made part of your claim file and is generally available for public inspection.
5. The information contained on this form is routinely shared with State, Federal or local government agencies.

### QUESTIONS AND ANSWERS ABOUT MARYLAND WORKERS' COMPENSATION LAW

#### **WHAT IS WORKERS' COMPENSATION?**

Workers' Compensation is an insurance program which your employer provides you with medical treatment and partial income replacement benefits and for any permanent disability you may have sustained.

#### **WHO PAYS?**

If your claim is found to be compensable, your weekly benefits and all medical bills will be paid by your employer or the insurance company, which represents your employer. Do not send bills to the Workers' Compensation Commission.

#### **HOW LONG DO I HAVE TO WORK TO BE COVERED UNDER WORKERS' COMPENSATION?**

You are covered from the first day you are on the job.

#### **HOW DO I KNOW IF THE COMPANY I WORK FOR IS COVERED BY WORKERS' COMPENSATION?**

In the upper right hand corner of your claim form will be the name of the insurance company covering your employer.

#### **WHEN SHOULD I REPORT THE ACCIDENT?**

You should report any accident to your employer immediately. A delay in reporting may affect your claim.

#### **HOW DO I FILE A CLAIM?**

If your employer does not have a claim form, the Workers' Compensation Commission will provide you with one and all the necessary information you may need. All forms are provided free of charge.

#### **WHAT DO I DO ABOUT A DOCTOR?**

If your employer does not provide a doctor, you may choose your own.

#### **WHO PAYS FOR THE DOCTOR?**

Your company will pay for your doctor's visit if the injury was caused by an accident on the job.

#### **WHAT MEDICAL TREATMENT WILL WORKERS' COMPENSATION INSURANCE PAY FOR?**

All doctor bills, hospital bills, physical therapy, prescriptions, and necessary expenses are covered by this insurance.

#### **WHEN AM I ENTITLED TO BENEFITS?**

You are entitled to benefits if you miss more than three (3) days from work. If you miss more than 14 days, you will be paid for the first three days, provided your employer did not pay you for any of these days. A claim number is assigned by the Commission and a consideration date is placed on the bottom of the form. The consideration date means we allow your employer or his insurer until that date to raise any objections they may have to your claim.

#### **HOW MUCH WILL MY WEEKLY BENEFITS BE?**

You should receive two-thirds of your average weekly wage, but not more than the State's average weekly wage for the year that the accident occurred.

#### **HOW LONG WILL I RECEIVE WEEKLY BENEFITS?**

You will receive benefits so long as you are unable to work because of the injury.

#### **WHAT IF MY INJURY PREVENTS ME FROM RETURNING TO MY JOB?**

If you are not capable of returning to your job or some other job for which you are qualified, you may be eligible for vocational rehabilitation. Call the Worker's Compensation Commission.

#### **WHAT KIND OF BENEFITS WILL I RECEIVE IF I HAVE PERMANENT DISABILITY?**

You will receive weekly benefits based on the type and extent of your permanent disability.

#### **WHAT HAPPENS AFTER I FILE A CLAIM?**

If you do not receive any benefits, you may request a hearing before the Workers' Compensation Commission. Your case will be decided by a Commissioner who listens to both sides of the case and determines what benefits if any, you should receive. The Commissioner's decision will be based on the law and facts involved.

#### **DO I HAVE TO HAVE A LAWYER?**

You may have an attorney of your choice to represent you, or you may represent yourself. The Commissioner can not be your attorney.

#### **WHO PAYS THE ATTORNEY?**

Do not pay money to anyone to assist you with your claim. If you hire a lawyer, the Commission will fix his fee. If an award is made to you, the fee will be deducted from your award and paid separately by the employer or insurance company to the attorney.

#### **WHAT IF I WANT TO HIRE A LAWYER BUT DON'T KNOW ONE?**

If you are a resident of Maryland, you may call the Lawyer Referral Service by dialing 539-3112 in Baltimore. You may also check your phone directory for the number of a local lawyer referral service.

THE ABOVE INFORMATION IS  
INTENDED TO BE ONLY  
A GENERAL GUIDE ON  
MARYLAND WORKERS' COMPENSATION



MONTGOMERY COUNTY  
FIRE AND RESCUE SERVICE

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Workers' Compensation Claims

xx/xx/15

Issued by: Fire Chief Scott E. Goldstein

Policy Number: XX-XX

Authority: Montgomery County Code Section 21-3 (b)

Supersedes: Montgomery County Fire and Rescue Commission Executive Regulation #29-90, Workers' Compensation Claims, dated 2/28/91, DFRS Policy and Procedure #801 Workers' Compensation Claims, dated 3/7/91, and Fire Chief's General Order #10-16, MCFRS Work-related Injury/Illness Investigations, dated 11/17/2010.

Effective Date: November 1, 2015

**SECTION 1. Purpose:**

This policy establishes a standard method for personnel to use when investigating and reporting MCFRS work-related injuries and illnesses.

**SECTION 2. Applicability:**

This policy and procedure applies to all MCFRS personnel.

**SECTION 3. Background:**

This policy and procedure consolidates two old MCFRS/DFRS policies and a former Fire Chief's General Order.

**SECTION 4. Definitions:**

- a. **Employer's First Report of Injury Form**: The form required by the State of Maryland to report a work-related injury or illness, and is required by Montgomery County to establish a workers' compensation claim.
- b. **FROMS**: Fire Rescue Occupational Medical Services.
- c. **Infectious Exposure**: A specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood, body fluids, or other potentially infectious material; inhalation of airborne pathogens; or ingestion of foodborne pathogens or toxins.
- d. **Injury**: An accidental injury arising out of and in the course of duty with MCFRS, as defined by the Maryland Workers' Compensation statute, and as interpreted by Maryland case law.



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- e. **Illness:** An ailment, disorder, sickness, or occupational disease which is the result of working under conditions inherent in the course of duty with MCFRS, as defined by the Maryland Workers' Compensation statute, and as interpreted by Maryland case law.
- f. **MEWS:** Medical Evaluation of Work Status Form.
- g. **MCSIP:** Montgomery County Self-Insurance Program.
- h. **Occupational Exposure:** An infectious exposure that resulted from performance of an individual's duties.
- i. **Risk Management Accountability Program (Risk MAP):** The electronic database maintained by the MCFRS Safety Section, used for reporting collisions, incidents, injuries, illnesses, and near misses.
- j. **Third Party Administrator (TPA):** A contractor of Montgomery County that is responsible for the County's 24-hour reporting service and Managed Care Program.

**SECTION 5. Policy:**

It is the policy of MCFRS to investigate, report, and manage work-related injuries and illnesses experienced by its personnel.

- a. All MCFRS work-related injuries and illnesses must be reported, regardless of whether or not the individual seeks treatment.
- b. The supervisor of personnel who suffer a work-related injury or illness must report the injury or illness to the TPA and their chain-of-command.
- c. All MCFRS Workers' Compensation claims must be reported through the Montgomery County Self-Insurance Program (MCSIP). Information and instructions on how to report a claim can be found at [www.mcsip.org](http://www.mcsip.org).
- d. All MCFRS work-related injuries/illnesses must be investigated and documented in Risk MAP. A work-related burn injury, exposure to communicable disease, or injury/illness that requires the individual to be admitted to the hospital must be investigated by the on-duty Safety Officer.
- e. MCFRS personnel who are off-duty and are injured while providing emergency fire, rescue, or EMS assistance in Montgomery County, Maryland, or while attending an MCFRS-approved training class, will be covered as if on-duty.

**SECTION 6. Responsibility:**

All MCFRS Personnel must report all work related injuries and illnesses to their Supervisor whether or not the individual seeks medical treatment.



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**SECTION 7. Procedure:**

**a. Personnel must:**

1. Report all work-related injuries or illnesses to their supervisor, no matter how minor;
2. Cooperate with, and provide truthful information regarding the incident to the Injury/illness investigator;
3. Provide a written statement to the injury investigator(s) describing the circumstances of the injury/illness;
4. Provide pertinent information regarding their condition to the TPA. If the individual is represented by an attorney such requests for information from the TPA will be made to the attorney of record for the claim.
5. Provide their licensed health care provider and/or hospital, with the information necessary, and inform the health care provider or hospital to send bills directly to the TPA or the injured party's Workers' Compensation Attorney for processing.

**b. Supervisors must:**

1. Arrange for immediate medical attention for personnel who sustain a work-related injury/illness, as necessary;
2. Notify the on-duty Battalion Chief, Safety Officer, or appropriate Chief Officer of the injury or illness, to start the investigation process;
3. Report the work related injury or illness through the MCSIP to the TPA. (See instructions at [www.mcsip.org](http://www.mcsip.org));
4. Identify any witnesses to the injury/illness and obtain witness contact information and, when possible, obtain a written statement; and
5. Assist the Injury Investigator as necessary.

**c. The Battalion Chief, Safety Officer, or appropriate Chief Officer is responsible for:**

1. Reporting immediately to the scene of the injury/illness;
2. Determining any additional resources needed to assist with the investigation;
3. Conducting the injury/illness investigation;
4. Ensuring the supervisor of the injured/ill personnel reports the injury/illness to the TPA;
5. Notifying the Duty Operations Chief(s), Safety Officer, and appropriate rostered Chief; and
6. Immediately notifying the Safety Chief of:
  - A. work-related injuries that result in hospitalization;
  - B. work-related death, amputation, loss of an eye; and
  - C. other severe work-related injuries or illnesses.



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- d. The Injury/Illness Investigator(s) is responsible for:
1. Reporting immediately to the scene and investigating the injury/illness;
  2. Determining whether an Injury Investigation Team is needed;
  3. Inspecting, documenting, and impounding as necessary, any Personal Protective Equipment or other equipment that is involved in the injury/illness;
  4. Gathering from all parties, information including, but not limited to:
    - A. the circumstances that led to the injury/illness;
    - B. photographs of the scene, and notes on the weather; and
    - C. statements from injured/ill personnel and witnesses.
  5. Determining cause of the injury or illness, preventability, corrective actions and reporting the findings in Risk MAP and notifying the appropriate Chief Officer;
  6. Completing a Risk MAP report within 24 hours and ensuring an AD5 report is sent to the Duty Operations Chief or appropriate Chief Officer for career personnel if a lost time injury/illness occurs;
  7. Ensuring that the required reports and statements of personnel are properly completed and submitted as required; and
  8. Notifying the appropriate LFRD Chief.
- e. The Duty Operations Chief is responsible for ensuring that this policy is followed and:
1. Ensuring that the injury/illness is properly investigated and reported;
  2. Ensuring that an injury investigator is assigned;
  3. Notifying the Fire Chief and other Chief Officers, as required;
  4. Ensuring the LFRD Chief or designee is notified when LFRD personnel sustain an injury/illness;
  5. Assisting, as needed, in providing replacement personnel to ensure that appropriate staffing is maintained;
  6. Assisting the Injury Investigator as necessary; and
  7. Reviewing AD5 requests and forwarding them as appropriate.
- f. The MCFRS Safety Section is responsible for:
1. All Risk MAP data, and reviewing all completed Risk MAP reports to ensure their accuracy and completeness;
  2. Conducting any follow-up investigation required;
  3. Attaching the First Report of Injury to the Risk MAP Report;



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4. Ensuring injury investigators are qualified, as established by MCFRS;
5. Notifying County Risk Management and/or Maryland Occupational Safety and Health Administration when there is a work-related:
  - A. Death;
  - B. Injury or illness that requires in-patient hospitalization;
  - C. Amputation, or
  - D. Loss of an eye.

**SECTION 8. Cancellation:**

This policy cancels and supersedes Montgomery County Fire and Rescue Commission Executive Regulation #29-90, Workers' Compensation Claims, dated 2/28/91, DFRS Policy and Procedure #801 Workers' Compensation Claims, dated 3/7/91, and Fire Chief's General Order #10-16, MCFRS Work-related Injury/Illness Investigations, dated 11/17/2010.

**SECTION 9. Attachments:**

- a. Medical Evaluation of Work Status (MEWS) Form.

**Approved:**

\_\_\_\_\_  
Scott E. Goldstein, Fire Chief

Montgomery County Fire and Rescue Service

\_\_\_\_\_  
Date