EXECUTIVE REGULATION

Montgomery County Fire and Rescue Commission

WORKERS' COMPENSATION CLAIMS	Number 29-90
MONTGOMERY COUNTY FIRE AND RESCUE SERVICE	Effective Date

MONTGOMERY COUNTY FIRE AND RESCUE COMMISSION REGULATION ON:

WORKERS' COMPENSATION CLAIMS

Issued by: Montgomery County Fire and Rescue Commission
Executive Regulation #29-90
Authority: Montgomery County Code Section 21-4B(e)(3)
Council Review: Method (2) under Code Section 2A-15
Register Vol. 31, Issue 9

SUMMARY: This Worker's Compensation Claims Regulation is being repealed because its Procedures are outdated. It established a uniform method for reporting and filing claims for on-duty injuries and occupational diseases sustained by Montgomery County Fire and Rescue Service (MCFRS) career and volunteer personnel. This regulation is 24 years old and its procedures no longer conform with current practices.

DEADLINE : Montgomery County *Register* Comment: September 30, 2014

ADDRESS: Send comments pertaining to the proposed REPEAL of this regulation to Beth Feldman, Montgomery County Fire and Rescue Service, 2nd Floor, 100 Edison Park Drive, Gaithersburg, Maryland 20878. E-mail comments to beth.feldman@montgomerycountymd.gov

BACKGROUND: This regulation 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. These personnel are covered by the County's Self-Insurance Program for accidental injury or occupational disease.

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[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 Worker's 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 an in the course of employment or volunteer service, as defined by the Maryland Workers' Compensation statute and as interpreted by Maryland case law.

(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 en route 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.

(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.

(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.

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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No.: 29-90

Effective Date:

TITLE: WORKERS' COMPENSATION CLAIMS

(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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Sec. 9. Appendices.

A. Supervisor's Incident Investigation Report

B. Employee's First Report of Injury

C. Workers' Compensation Commission Form MP-C1]

Isiah Leggett,
County Executive

Date

APPROVED AS TO
FORM AND LEGALITY
OFFICE OF COUNTY ATTORNEY
BY
DATE 6/11/2014

APPENDIX A SHEET 3

(O) CONTRIBUTING CAUSES OF THE INCIDENT: HAZARDOUS CONDITIONS

1173- Actions of Others
1174- Assembly or Design Flaws
1175- Assignment of Personnel/Work Shifts
1176- Atmosphere/Ventilation
1177- Congestion/Housekeeping
178- Dress/Apparel
79- Fire Hazard
180- Guard or Safety Device
1181- Illumination/Glare
1182- Labeling/Warning
1183- Maintenance
1184- Natural Environment/Weather
1185- Noise
1186- Person Who is Violent/Combative/ Intoxicated/Otherwise Affected
1187- Sharp or Protruding (Not for Knives, Blades, or Other Intentionally Sharp Objects)
1188- Slippery (Not Walking/Working Surfaces)
1189- Storing/Stacking/Securing/Shoring
1190- Tool/Equipment Damage
1191- Walking/Working Surfaces
1192- Worn or Deteriorated
1193- Other Hazardous Condition Not Listed; Specify Below: _____

(P) CONTRIBUTING CAUSES OF THE INCIDENT: UNSAFE ACTS

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

(Q) INJURY/ILLNESS/EXPOSURE TREATMENT/OUTCOME

2010 On-the-Job Fatality
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 Conciousness

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. ___ ___ ___ ___ ___ ___

2012 Immediate First Aid or Immediate Medical Treatment Administered Only Cases
WITH
-No Restriction of Work Activities or Bodily Motion
-No Loss of Conciousness
-No Assignment to Another Job Position
-No Fractures

2013 No Treatment Required at this Time

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

PARKING-RELATED INCIDENTS
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, Animanl, 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)

(20 30 31 32 33 34 35 36 37 38 39 40 41 42

43- Single Vehicle or Parking Incident
44- Backing Incident
45- Non-Collision
46- Unknown/Other

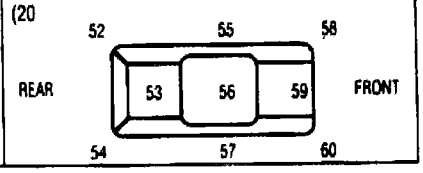
(U) COUNTY VEHICLE DAMAGE

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



(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 DOT ___ ___ ___ ___ ___ ___

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

DATE _____ INIT _____

Rev. 6/90

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 WORKMEN'S COMPENSATION COMMISSION
10[illegible]INGTON STREET, BALTIMORE, MD. 21202

PLEASE PRINT OR TYPE

DO NOT WRITE IN THIS SPACE

WCC CLAIM #

DOCTOR'S REPORT Yes ☐ No ☐

SOUNDEX #

1. [illegible]oyer Name
2 Mail Address

Federal Employer Identification Number (FEIN)

LABS LOCA CODE

PLEASE CHECK

☐ MONTGOMERY COUNTY GOVERNMENT
100 MARYLAND AVE., ROCKVILLE, MD. 20850 — PHONE 279-1956

☐ MONTGOMERY COUNTY PUBLIC SCHOOLS
850 HUNGERFORD DRIVE, ROCKVILLE, MD. 20850 — 279-3611

☐ MONTGOMERY COLLEGE
51 MANNAKEE STREET, ROCKVILLE, MD. 20850 — 762-6088

☐ OTHER _____

3 Nature of Business—(Manufacturing steel, 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 AM ☐ PM ☐

When did you or foreman first know of injury?

Name of foreman (Name)

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 ☐

If Did you have an [illegible] 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

Name and address of hospital

28 FATAL CASES — Has injured died
Yes ☐ No ☐

If yes give date of death

Date of this report

Form Name

Prepared by

Signed by

Official Title

Attachment to Resolution No. 12-53_ APPENDIX C

EMPLOYEE'S CLAIM

Claim No.

WORKERS' COMPENSATION COMMISSION

6 NORTH LIBERTY STREET
BALTIMORE, MARYLAND 21201-3785
BALTIMORE PHONE (301) 333-4700
TOLL FREE PHONE 1-800-492-0479 IN MARYLAND
BALTIMORE TTY FOR DEAF 383-7555

Co

Co. Claim No

Insurance Co. and Code No.

Commission has received — Yes / No
Employer's Report
Doctor's Report

DO NOT WRITE IN SPACE BELOW

First Name | Middle Name | Last Name | 2. Phone No.

Mailing Address | City | County | State | Zip Code

Social Security Number | 5. Sex | 6. Date of Birth | 7. Single ☐ Married ☐ | 8. What was your regular work?

Gross wages or earnings (including Tips, Bonus, Overtime, Allowances) at time of accident — Per week | 10. Were you paid full wages for the day of the accident? Yes ☐ No ☐ | 11. What was your work when injured?

12. Full and correct business name of your employer

Complete address

City | State | Zip Code

Employer phone no.

13. Nature of Employer's business (type business, work done, kind of trade, etc.)

14. Location where accident occurred

15. Name of Foreman | Have you given him/her notice of injury? Yes ☐ No ☐

16. 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.

Date of Accident: month | day | year 19 | at | am ☐ pm ☐

18. If occupational disease, give date of disablement.

Describe how accidental injury occurred

OR describe how occupational disease occurred

What member of your body was injured?

21. Has injury resulted in amputation Yes ☐ No ☐ | If yes, describe loss

Did you request your employer to provide medical care? Yes ☐ No ☐ | Has he done so? Yes ☐ No ☐

23 Have you returned to work? If "Yes", on what date did you return? Yes ☐ No ☐

Name and Address of Attending Physician:

25. If an Attorney is representing you in this case give his name, address and phone no.

Were you in a hospital? If "Yes", give name and address of hospital: Yes ☐ No ☐

Is this the only Workers' Compensation claim you have filed for this Accident or Occupational Disease? Yes ☐ No ☐ If "No", give claim no.

If Health Insurance used, give name of Insurance Co.

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, nd in support of it I make the foregoing statement of facts.

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

ATE _____ 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 Commision on or before an appropriate award will be passed.

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

1 INS CO 1
2 ATTY
3 INS CO 2
4 ATTY
5 EMPLOYER
6 EMP. ATTY.
7 CLMT ATTY
8 CAUSE
9 BODY LOC.
10 CLASS CODE
11 N. OF I.
12 INDUSTRY
13 M.I.
14 ILL. EMP
15 O.D
16 MEDICAL
17 HEALTH
18
19
20
21
22
23
24
25

IMPORTANT: It is the responsibility of the employee to provide this commission with their claim number. Always include claim number on any correspondence.

DISCLOSURE PURSUANT TO EXECUTIVE ORDER 01.01.1983.18

1. The personal information requested on this form in 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.

W DO I KNOW IF THE COMPANY I WORK FOR OVERED 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.