



## INJURY REPORT PACKET

During Maryland Responds Medical Reserve Corps authorized activities, volunteers are considered to be State employees and therefore have workers' compensation benefits. Injuries sustained during a Maryland Responds Medical Reserve Corps authorized activity must be documented using the forms contained in this packet. All completed forms must be submitted to the Maryland Responds MRC Program Office via email ([mdresponds.health@maryland.gov](mailto:mdresponds.health@maryland.gov)) or via fax (410-333-5000).

### INSTRUCTIONS:

1. Inform a Maryland Responds State Administrator of your injury by using the contact information below.  

Amanda Driesse	Lornah Misati
Desk Phone: 410-767-7772	Desk Phone: 410-767-0959
Cell Phone: 443-934-5849	Cell Phone: 443-865-7802
2. The injury should be documented using the following forms:
  - Injured volunteer completes the Employee's Report of Injury Form (page 2). If you are physically unable to fill out the Employee's Report of Injury Form, you can fill it out at a later time, or have someone fill it out on your behalf.
  - A Maryland Responds State Administrator or other responsible administrative official completes the Supervisor's Accident Investigation Form (page 3) and the Authorization for Examination or Treatment Form (page 5).
  - Any witness to the accident completes the Accident Witness Statement (page 4).
3. Submit completed forms to the Maryland Responds MRC Program Office via email ([mdresponds.health@maryland.gov](mailto:mdresponds.health@maryland.gov)) or via fax (410-333-5000) within three (3) days of the incident. A State Administrator will forward the forms to the appropriate authority.
  - Make and keep copies of these forms for your files. These completed forms can provide valuable information in a claims investigation of an injury and for developing the defense in the event of a workers' compensation hearing.
4. If you require treatment from a health care professional, you can be seen on a walk-in basis at any of the WorkPro Occupational Health or Occupational Medical Services (OMS) locations. It is recommended that this be done within three (3) days of the incident. For locations and office hours, see pages 6 and 7.
  - Contact the Maryland Responds MRC Program Office/State Administrators to notify them of which WorkPro location you will be visiting for treatment. This is necessary so that we may fax the Authorization for Examination or Treatment Form (page 5) to them prior to your visit.

### MARYLAND RESPONDS MEDICAL RESERVE CORPS



### MARYLAND RESPONDS STATE PROGRAM

Maryland Department of Health  
Office of Preparedness and Response  
300 W. Preston Street, Suite 202, Baltimore. MD 21201  
Email: [mdresponds.health@maryland.gov](mailto:mdresponds.health@maryland.gov)  
Fax: 410-333-5000



# Supervisor's Accident Investigation

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

Location where accident occurred		Employer's Premises: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of accident or illness
		Job site: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Who was injured?		<input type="checkbox"/> Employee <input type="checkbox"/> Non-Employee	Time of accident a.m. or p.m.
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? Property/equipment owned by:
What property/equipment was damaged?			
What was employee doing when injury/illness occurred? What machine or tool was being used? What type of operation?			
How did injury/illness occur? List all objects and substances involved.			
Part of body affected/injured?		Any prior physical conditions? If so, what? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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"/> Failure to lockout        | <input type="checkbox"/> Failure to secure             | <input type="checkbox"/> Horseplay                     |
| <input type="checkbox"/> Improper dress            | <input type="checkbox"/> Improper guarding             | <input type="checkbox"/> Improper instruction          |
| <input type="checkbox"/> Improper maintenance      | <input type="checkbox"/> Improper protective equipment | <input type="checkbox"/> Inoperative safety device     |
| <input type="checkbox"/> Lack of training or skill | <input type="checkbox"/> Operating without authority   | <input type="checkbox"/> Physical or mental impairment |
| <input type="checkbox"/> Poor housekeeping         | <input type="checkbox"/> Poor ventilation              | <input type="checkbox"/> Unsafe arrangement or process |
| <input type="checkbox"/> Unsafe equipment          | <input type="checkbox"/> Unsafe position               | <input type="checkbox"/> Other _____                   |

Supervisor's corrective action to ensure this type of accident does not recur: \_\_\_\_\_

Was employee trained 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 \_\_

Did employee promptly report the injury/illness? \_\_\_\_\_ Yes \_ No \_\_

Is there modified duty available? \_\_\_\_\_ Yes \_ No \_\_

Supervisor's name

Supervisor's signature

Phone#

Date

# Accident Witness Statement

(To be completed by accident witness)

Injured employee's name: \_\_\_\_\_  
Last First Middle

Name of witness: \_\_\_\_\_ Ph# \_\_\_\_\_  
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: (including events that occurred immediately before the accident):

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

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Recommendation on how to prevent this accident from recurring: \_\_\_\_\_

Name of Witness's Supervisor: \_\_\_\_\_ Ph# \_\_\_\_\_  
Last First

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_



**WORKPRO**  
OCCUPATIONAL HEALTH



**OCCUPATIONAL  
MEDICAL SERVICES**  
Your Partner in Employee Health

## State of Maryland

### Authorization for Examination or Treatment

(Patient Must Present Photo ID at Time of Service)

Agency: \_\_\_\_\_

(List Agency or Sub-Agency to Receive Invoice)

Today's Date: \_\_\_\_\_

Appointment Date/Time (if any): \_\_\_\_\_

Location: \_\_\_\_\_

Authorized By: \_\_\_\_\_

Agency Phone No.: \_\_\_\_\_

Agency Fax No: \_\_\_\_\_

Employee: \_\_\_\_\_

Employee Date of Birth: \_\_\_\_\_

*Please check all that apply:*

**Work Injury/Illness** Date of Injury \_\_\_\_\_ Claim# (if available) \_\_\_\_\_

#### Physical Examination

Pre-placement     Pre-placement w Ergonomic Assessment     DOT - Regulated

Fitness for Duty/Ability to Work     Medical Surveillance     FAA - MDOT

Other: \_\_\_\_\_

#### Substance Abuse Testing

DOT - Regulated Drug Test     MDOT Non-regulated Drug Test

DOT - Regulated Alcohol (Breath)     MDOT Non-regulated Alcohol Test (Saliva)

Other: \_\_\_\_\_

#### Reason for Substance Abuse Testing

Pre-employment     Reasonable Suspicion     Post-accident     Random

Follow-up     Return to Duty

#### Psychological Services (scheduled through WORKPRO Elkridge MD location)

Psychological Testing     SAP     Critical Incident Management

#### Other Services

Respirator Fit Test     Audiogram     PPD     Pulmonary Function Test     EKG

Chest X-ray     Vaccination: \_\_\_\_\_     Other: \_\_\_\_\_

Special instructions/comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**WORKPRO Occupational Health Locations  
&  
Occupational Medical Services (OMS) Locations  
Effective 4/1/17**

*Note: Contact Names, Numbers, Emails to follow.*

**WORKPRO Maryland**

6785 Business Parkway, Suites 1&2  
Elkridge, MD 21075  
Hours: Mon – Fri 7:30am – 4:30pm

844 Washington Road, Unit 203  
Westminster, MD 21157  
Hours: Mon – Fri 7:30am – 4:30pm

2618 North Salisbury Blvd, Suite 130  
Salisbury, MD 21801  
Hours: Mon – Fri 7:30am – 4:30pm

**Opening Date: 4/1/17**

2875 Crain Highway  
Route 301 South  
Waldorf, MD 20601  
Hours: Mon – Fri 7:30am – 4:30pm

14302 Barton Boulevard SW  
Cumberland, MD 21502  
Hours: Mon – Fri 7:30am – 4:30pm

**WORKPRO Delaware**

914 Justison Street  
Shipyard Shops  
Wilmington, DE 19801  
Hours: Mon - Fri 7:30am – 5:00pm

4051 Ogletown-Stanton Road, Suite 102  
Iron Hill Corporate Center, Sabre Wing  
Newark, DE 19713  
Hours: Mon - Fri 7:30am – 5:00pm

283 North DuPont Highway  
Kohl's Center  
Dover, DE 19901  
Hours: Mon – Fri 7:30am – 4:30pm

543 North Shipley Street  
Professional Building, Suite F  
Seaford, DE 19973  
Hours: Mon - Fri 7:30am – 4:30pm

503 W. Market Street, Suite 100  
Nanticoke Immediate Care  
Georgetown, DE 19947  
Hours: Mon - Fri 7:30am – 4:30pm

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**OMS Locations**

**Arbutus**

4807 Benson Avenue  
Baltimore, MD 21227  
*Hours: Open 24 Hrs*

**Belcamp**

1200 Brass Mill Road, Suite C  
Belcamp, MD 21017  
Hours: Mon – Fri 7:00am – 5:00pm

**Canton**

3600 O'Donnell Street, Suite 170  
Baltimore, MD 21224  
Hours: Mon – Fri 7:30am – 5:00pm

**Greenbelt:**






7933 Belle Point Drive,  
Greenbelt, MD 20770  
Hours: Mon – Fri 8:00am – 4:30pm

# State of Maryland - WORKPRO & OMS





## WORKPRO DE Sites

-  WORKPRO, Wilmington DE
-  WORKPRO, Newark DE
-  WORKPRO, Dover DE
-  WORKPRO, Georgetown DE
-  WORKPRO Seaford DE

## WORKPRO Maryland

-  WORKPRO/Pivot, Westminster
-  WORKPRO Salisbury
-  6785 Business Pkwy - Elkridge
-  WORKPRO Cumberland
-  WORKPRO, Waldorf

## Occupational Medical Services

-  OMS, B'More (Arbutus)
-  OMS, B'More (Canton)
-  OMS, Belcamp
-  OMS, Greenbelt

