Work-Related Injury and Illness Reporting

1022.1 PURPOSE AND SCOPE

The purpose of this policy is to provide guidance regarding timely reporting of work-related injuries and occupational illnesses.

1022.1.1 DEFINITIONS

Definitions in this policy include:

Work-related injury or illness - Accidental personal injury or illness arising out of and in the course of employment (Md. Code LE § 9-101).

1022.2 POLICY

The University of Maryland, Baltimore Police Department will address work-related injuries and occupational illnesses appropriately, and will comply with applicable state workers' compensation requirements (Md. Code LE § 9-101 et seq.).

See attachment: Out of State-First Report of Injury-Sept_2019.pdf

See attachment: SV-Rpt-Sept_2019.pdf

See attachment: Witness-Statement-Sept_2019.pdf

1022.3 RESPONSIBILITIES

1022.3.1 MEMBER RESPONSIBILITIES

Any member sustaining any work-related injury or occupational illness shall report such event as soon as practicable, but within 24 hours, to a supervisor, and shall seek medical care when appropriate.

1022.3.2 SUPERVISOR RESPONSIBILITIES

A supervisor learning of any work-related injury or occupational illness shall ensure the member receives medical care as appropriate.

Supervisors shall ensure that required documents (i.e., Employee's First Report of Injury, detailed memorandum describing the incident, etc.) are completed as soon as practicable through the chain of command to their respective Bureau Commander for review and processing. Supervisors at each level shall endorse the documents when forwarding them to their respective Bureau Commander.

Supervisors shall determine whether the Major Incident Notification (Policy 327) and the Workplace Safety and Health (Policy 1031) policies apply and take additional action as required.

1022.3.3 SUPPORT SERVICES BUREAU COMMANDER RESPONSIBILITIES

The Commander of the Support Services Bureau will serve as the Liaison Officer with the Health Risk Manager of the UMB Environmental Health and Safety (EHS). The Commander of the

Support Services Bureau or designee will be responsible for ensuring the required documents are compiled, reviewed for accuracy and completeness, and forwarded to EHS.

1022.3.4 DIVISION COMMANDER RESPONSIBILITIES
The Bureau Commander who receives a report of a work-related injury or occupational illness shall review the report for accuracy and determine what additional action should be taken. The reports shall then be forwarded through the chain of command to the Chief of Police. The Commander of the Support Services Bureau shall be copied when submitting the report through the chain of command to the Chief. This will afford the Commander of the Support Services Bureau an opportunity to confer with the Health Risk Manager of EHS to ensure UMBPD complies with any required Maryland Occupational Safety and Health (MOSH) Act reporting. Once the appropriate reports are approved by the Chief of Police, the Commander of the Support Service Bureau or designee will be responsible for ensuring the reports are forwarded to EHS.

1022.3.5 CHIEF OF POLICE RESPONSIBILITIES
The Chief of Police or authorized designee shall review and forward copies of the report to the Human Resource Services. Copies of the report and related documents retained by the Department shall be filed in the member's confidential medical file and retained according to the retention schedule.

1022.3.6 ENVIRONMENTAL HEALTH AND SAFETY RESPONSIBILITIES
EHS shall ensure the required documents regarding workers' compensation are completed and forwarded promptly to the State Worker's Compensation Commission (Md. Code LE § 9-707).

1022.4 OTHER INJURY OR ILLNESS

Injuries and illnesses caused or occurring on-duty that do not qualify for workers' compensation reporting shall be documented on the designated report (Form 95 or detailed memorandum),, which shall be signed and endorsed by his/her supervisor. The report shall be forwarded through the chain of command and a copy sent to the appropriate Bureau Commander.

Unless the injury is extremely minor, this report shall be signed by the affected member, indicating that he/she desired no medical attention at the time of the report. By signing, the member does not preclude his/her ability to later seek medical attention.

1022.5 SETTLEMENT OFFERS

When a member sustains a work-related injury or occupational illness that is caused by another person and is subsequently contacted by that person, his/her agent, insurance company or attorney and offered a settlement, the member shall take no action other than to submit a written report of this contact to his/her supervisor as soon as possible. The receiving supervisor shall forward the report through the chain of command to the Chief of Police.

1022.5.1 NO SETTLEMENT WITHOUT PRIOR APPROVAL
No less than 10 days prior to accepting and finalizing the settlement of any third-party claim arising out of or related to a work-related injury or occupational illness, the member shall provide the

Chief of Police with written notice of the proposed terms of such settlement. In no case shall the member accept a settlement without first providing written notice to the Chief of Police. The purpose of such notice is to permit the Department an opportunity to determine whether the offered settlement will affect any claim the UMBPD may have regarding payment for damage to equipment or reimbursement for wages against the person who caused the accident or injury, and to protect the Department's right of subrogation, while ensuring that the member's right to receive compensation for injuries is not affected.

Attachments

OutofState-FirstReportofInjury-Sept_2019.pdf

INSTRUCTIONS
FOR COMPLETING EMPLOYEE FIRST REPORT OF INJURY
FOR OUT OF STATE CLAIMS

This form is only to be used by employees who are injured while working outside the State of Maryland. If you are an Employee Working Out Of State With Special Coverage,[1] use the "Employee's First Report of Injury FOR OUT OF STATE CLAIMS" form to report an occupational injury or exposure.

Carrier: Zurich American Insurance Company

Carrier's Claims Reporting Phone Number: Phone #: 1-800-987-3373
Fax #: 1-877-962-2567

Insured: University of Maryland Baltimore
Contact: EHS Risk Management (410) 706-7055 EHSRiskManagement@umaryland.edu

STEPS:

1. If necessary, obtain immediate medical assistance. Advise the medical provider this is a workers' compensation claim.
2. Complete the Employee's First Report of Injury form. Fax it to EHS, Risk Management at 410-706-8212.
3. Notify your supervisor as soon as possible. Ask your supervisor to complete the Supervisor's Report and submit it to EHS as soon as possible.
4. If you will miss any time from work due to your injury, please have your healthcare provider supply a signed medical slip documenting your absence and provide the slip along with any other medical documentation to your supervisor and a copy to EHS.
5. Keep your supervisor and EHS advised of your progress.

[1] EMPLOYEE WORKING OUT OF STATE WHO REQUIRES SPECIAL COVERAGE:

An employee requires special workers' compensation coverage if the employee is:

- Assigned or permitted to work outside Maryland on a regular basis, with 50% or more of the employee's UM job-related duties to be *Work Out of State*. Work at home is *Work Out of State* if the employee's residence is not in Maryland.
- Required to *Travel on a Recurring Basis* to other states to carry out UM employment responsibilities, with 50% or more of the employee's UM job-related duties to be *Work Out of State*.
- Assigned or permitted to perform more than 50% of the employee's UM job-related duties as *Work Out of State* through a combination of out-of-state work place, out-of-state travel, and out of state work at home.
- Assigned to live and work in a foreign country, with 50% or more of the employee's UM job-related duties to be performed outside the United States, unless the *Employment Contract* was *Made in the U.S.*

Employee's First Report of Injury

FOR OUT OF STATE CLAIMS ONLY

(To be completed by employee at time of accident)

UNIVERSITY OF MARYLAND BALTIMORE

WC Policy: Zurich American Insurance Company **CLAIM #**: _____

Employee Name: _____ EMPL ID: _____
Last **First** **Middle**

Date of Birth: _____ Marital Status:_____ Phone: _____

No. of Dependents: _____ Full Time or Part Time *(circle one)*: FT / PT

Home Address: _____
Address **City** **State** **Zip Code**

Supervisor: _____
Last **First**

When was accident reported to Supervisor? Date: _____ Time: _____ am / pm

Accident Date: _____ Time: _____ am / pm Time Shift Began: _____

Accident Location: _____
Address **City** **State** **Zip code**

Describe fully how accident occurred *(your activities at that time)*: _____

_____

_____

Describe bodily injury and specific part*(s)* of body affected: _____

_____

Was medical treatment sought? If so, where? _____
Address

_____
City **State** **Zip Code** **Phone**

Name*(s)* of witness*(es)*: _____
Name **Phone**

Not valid unless signed. By signing this form, I acknowledge that all statements made herein are true to the best of my knowledge.

Signature of employee: _____ Date: _____

****FAX Immediately to: EHS Risk Management, (410) 706-8212****

SV-Rpt-Sept_2019.pdf

Supervisor's Investigation Report

(To be completed by employee's supervisor at time of accident)

UNIVERSITY OF MARYLAND

Location where accident occurred		Employer's Premises: Yes ☐ No ☐ Job site: Yes ☐ No ☐	Date of accident or illness
Who was injured?		☐ Employee ☐ Non-Employee	Time of accident a.m. ☐ 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?
What property/equipment was damaged?			Property/equipment owned by:
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? Yes ☐ 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

____ Failure to lockout	____ Improper maintenance	____ Poor housekeeping
____ Failure to secure	____ Improper protective equipment	____ Poor ventilation
____ Horseplay	____ Inoperative safety device	____ Unsafe arrangement or process
____ Improper dress	____ Lack of training or skill	____ Unsafe equipment
____ Improper guarding	____ Operating without authority	____ Unsafe position
____ Improper instruction	____ Physical or mental impairment	____ 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

***Fax immediately to: EHS Risk Management (410) 706-8212**

Please fill in all fields noted in RED

Witness-Statement-Sept_2019.pdf

Accident Witness Statement
(To be completed by accident witness)

Employer: **University of Maryland**		
Employee: (First)	**(Last)**	
Location of accident	**Building:**	**Area (hallway, etc.):**
Date of accident:	**Time of accident:**	
Describe fully how accident occurred:		
Describe bodily injury sustained (be specific about part(s) of body affected):		
Name of witness: (First)	**(Last)**	
Witness Phone:		
Signature of witness:		**Date:**

Fax Immediately to: EHS Risk Management (410)706-8212 Revised: 09/19