Exhibit A

WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

GENERAL

EMPLOYER (NAME & ADDRESS INCL ZIP)

Howard County Public School System
10910 Route 108
Ellicott City, MD 21042

CARRIER/ ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE

JURISDICTION

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)

LOCATION #

SIC CODE

EMPLOYER FEIN

52-6000968

PHONE #

(410) 313-6600

CARRIER / CLAIMS ADMIN

CARRIER (NAME, ADDRESS & PHONE NO)

Self Insured

POLICY PERIOD

TO

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

SISCO
RCM&D Self-Insured Services, Co, Inc.
555 Fairmount Avenue
Baltimore, MD 21286-5497
(410) 339-7263

CHECK IF APPROPRIATE

SELF INSURANCE X

CARRIER FEIN

POLICY/SELF-INSURED NUMBER

1508

ADMINISTRATOR FEIN

AGENT NAME& CODE NUMBER

EMPLOYEE

NAME (LAST, FIRST, MIDDLE)

DATE OF BIRTH

SOCIAL SECURITY NUMBER

DATE HIRED

STATE OF HIRE

MD

ADDRESS (INCL ZIP)

SEX

M MALE
F FEMALE
U UNKNOWN

MARITAL STATUS

U UNMARRIED SINGLE/DIVORCED
M MARRIED
S SEPARATED
K UNKNOWN

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

TELEPHONE (INCLUDE AREA CODE)

OF DEFENDANTS

NCCI CLASS CODE

WAGE

RATE

PER: DAY WEEK MONTH OTHER:

DAYS WORKED/WEEK

FULL PAY FOR DAY OF INJURY? YES NO

DID SALARY CONTINUE? YES NO

TIME EMPLOYEE AM PM

DATE OF INJURY/ILLNESS

TIME OF OCCURRENCE AM PM

LAST WORK DATE

DATE EMPLOYER NOTIFIED

DATE DISABILITY BEGAN

OCCURRENCE

CONTACT NAME/PHONE NUMBER

cell

TYPE OF INJURY/ILLNESS

PART OF BODY AFFECTED

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? YES NO

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQIUPMENT, MATERIALS OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS / ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK

IF FATAL,GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? YES NO

WERE THEY USED? YES NO

TREATMENT / OTHER

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT

0 NO MEDICAL TREATMENT
1 MINOR: BY EMPLOYER
2 MINOR CLINIC/HOSP
3 EMERGENCY CARE
4 HOSPITALIZED ▷ 24 HRS
5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

WITNESS (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE

Princ/Supvr's Signature

PHONE NUMBER

FORM IA -1 (3/09)

SEE BACK FOR IMPORTANT INFORMATION/OSHA REQUIREMENTS

IAIABC 1993
WCER3N 1

Exhibit B

HOWARD COUNTY
PUBLIC SCHOOL SYSTEM

OFFICE OF SAFETY, ENVIRONMENT AND RISK MANAGEMENT
Ronald_Miller@hcpss.org **410-313-6739**
Catherine_McLin@hcpss.org **410-313-7494**
Fax 410-313-7177

EMPLOYEE INCIDENT/INJURY REPORT

Please complete this form immediately for all job-related injuries or illnesses. Print this form and answer all questions completely. Ask your supervisor/principal for assistance if you do not understand the questions or need help completing this form. After you have completed Section I, return the form to your supervisor/principal to complete and sign Section II. Submit the completed form to the Office of Safety, Environment and Risk Management within 48 hours of the injury/illness. **Serious injuries or 911 calls must be reported immediately.**

SECTION I: Completed by the injured employee.

Employee Name: _____ Employee Number: E_____

Job Title: _____ Home/Cell Phone: _____

School/Facility: _____Incident Date: _____ Incident Time: _____ AM/PM

Incident Location (hallway, classroom, etc): _____

Describe in detail what happened. _____
_____
_____
_____

Names of persons who witnessed the incident: _____
_____

When did you report the incident? _____ Who did you report it to? _____

Did you seek medical treatment? Yes/No

Where were you treated? ☐Concentra ☐ Howard County General Hospital ☐ Other _____

Please provide address and phone number of location where treated. _____
_____
_____

Injured Part of Body and Type of Injury? (i.e. right ankle sprain) _____
_____

Signature of Employee _____ Date _____

Section II: Completed and signed by the supervisor and principal.

Who informed you of the incident? _____
How were you informed? _____ When? _____
List any additional information that you may have concerning how the injury occurred.
_____
_____

Please circle any accident causes which contributed to this incident:

Housekeeping – unsafe storage, clutter, items on floor, congested work area, untidy work area
Physical safeguards – unguarded machinery, warning signs not posted, inadequate protective equipment, defective equipment
Task Methods – disregard of instructions, operating without authority, unsafe loading/unloading, unsafe posture/position, poor lighting, unsafe methods/procedures/processes, poor ventilation, safeguards not provided, protective equipment not provided, use of equipment/materials unsafely
Supervision – inadequate direct supervision, failure to enforce rules, toleration of unsafe practices, protective equipment not used
Other – combative student, horseplay, substance use, improper clothing, improper footwear, weather

What action have you taken to prevent the incident from recurring? _____
_____
_____

Could use of protective equipment (scrub boots, eyewear, etc) prevent this injury? Yes/No

If this was the result of an auto accident, provide name, address, and insurance information driver/owner: _____
_____
_____

If this was the result of a human bite/scratch, refer employee to health assistant/cluster nurse for notification requirements.

Has employee returned to work? Yes/No If yes, when? _____

Was there any lost time from work? Yes/No If yes, dates? _____

Are you able to modify the employee's duties to accommodate the work restrictions? Yes/No

If no, contact the Office of Safety, Environment and Risk Management immediately for job placement of the injured employee.

Signature of Supervisor _____ Date _____

Signature of Principal/Facility Manager _____ Date _____

Keep a copy for your record.
Rev 8/14

Exhibit C

Concentra™

(Patient Must Present Photo ID at Time of Service)

Authorization for Examination or Treatment

Patient Name: _____ Social Security Number: _____

Employer: _____ Date of Birth: _____

Street Address: _____ Location Number: _____

Temporary Staffing Agency: _____

Work Related

❑ Injury ❑ Illness

Date of Injury _____

Substance Abuse Testing* (check all that apply)

❑ Regulated drug screen ❑ Breath alcohol

❑ Collection only ❑ Hair collect

❑ Non-regulated drug screen ❑ Rapid drug screen

❑ Other _____

Type of Substance Abuse Testing

❑ Preplacement ❑ Reasonable cause

❑ Post-accident ❑ Random

❑ Follow-up

Physical Examination

❑ Preplacement ❑ Baseline ❑ Annual ❑ Exit

DOT Physical Examination

❑ Preplacement ❑ Recertification

Special Examination

❑ Asbestos ❑ Respirator ❑ Audiogram

❑ Human Performance Evaluation*

❑ HAZMAT ❑ Medical Surveillance

❑ Other _____

Billing (check if applicable)

❑ Employee to pay charges

Special instructions/comments: _____

_____

_____

_____

★ Due to the nature of these specific services, only the patient and staff are allowed in the testing/treatment area. Please alert your employee so that they can make arrangements for children or others that might otherwise be accompanying them to the medical center.

Authorized by: _____ Title: _____

Please print

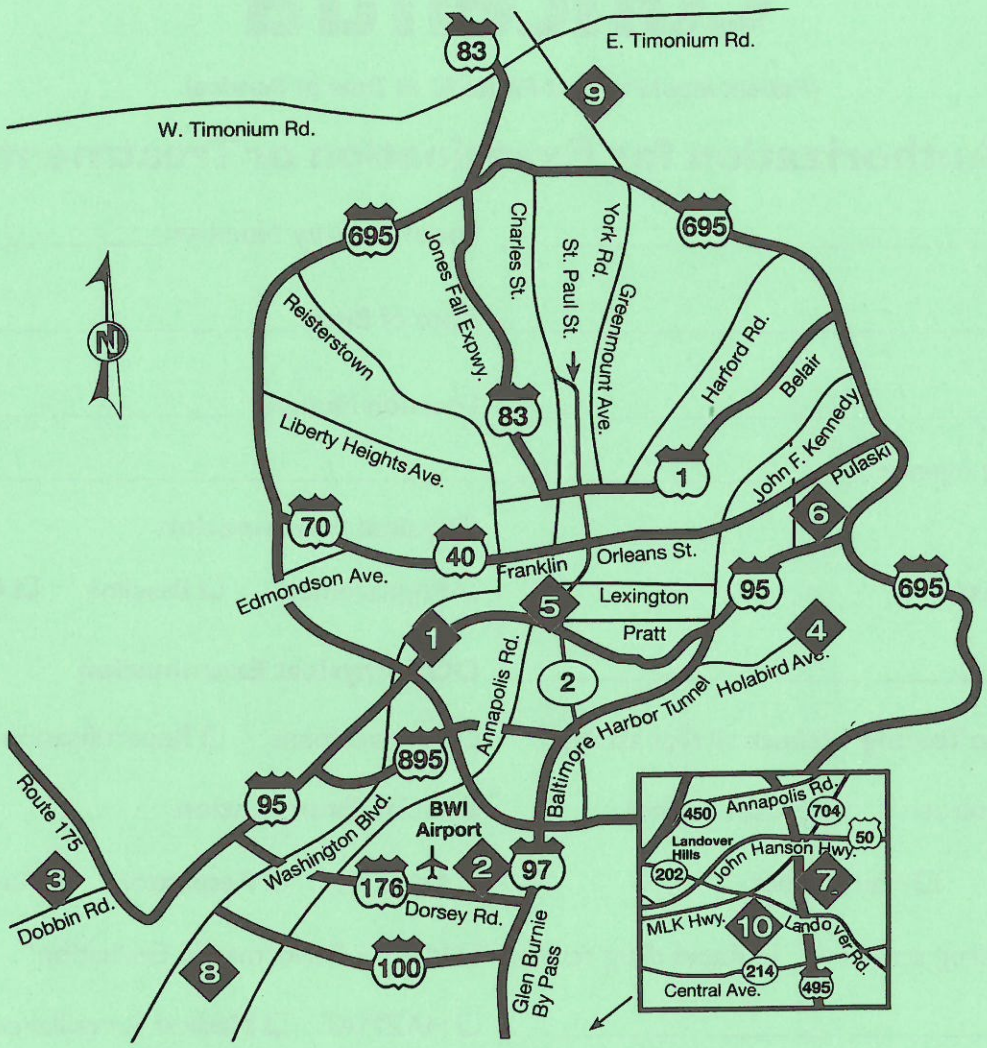
Phone: (_____) _____ _____

Date

Concentra now offers urgent care services for non-work related illness and injury. We accept many insurance plans.

(Copies of this form are available at www.concentra.com)

C2110AUTH



1 Arbutus
AFTER HOURS FACILITY
1419 Knecht Ave.
Baltimore, MD 21227
Mon: 7 am - Sat: 12 pm
410.247.9595
FAX: 410.247.7553

2 BWI Airport
811 Cromwell Park Dr.
Suite 104-105
Glen Burnie, MD 21061
Mon - Fri: 7:30 am - 5 pm
410.553.0110
FAX: 410.553.0197

3 Columbia
6656 Dobbin Rd.
Columbia, MD 21045
Mon - Fri: 8 am - 5 pm
410.381.1330
FAX: 410.381.5585

4 Dundalk
Holabird Business Park
1833 Portal St.
Baltimore, MD 21224
Mon - Fri: 8 am - 5 pm
410.633.3600
FAX: 410.633.3604

5 Downtown
100 S. Charles St., Ste. 150
Baltimore, MD 21201
Mon - Fri: 8 am - 5 pm
410.752.3010
FAX: 410.539.7023

6 Rosedale
8101 Pulaski Hwy., Ste. H
Baltimore, MD 21237
Mon - Fri: 7 am - 7 pm
Sat: 7 am - 12 pm
410.687.6462
FAX: 410.687.2261

7 Lanham
4451 G Parliament Pl.
Lanham, MD 20706
Mon - Fri: 7 am - 8 pm
Sat: 7 am - 12 pm
301.459.9113
FAX: 301.459.1214

8 Jessup
7377 Washington Blvd.
Suite 101
Elkridge, MD 21075
Mon - Fri: 8 am - 5 pm
410.379.3051
FAX: 410.379.3074

9 Timonium
Yorkridge Center
1840 York Rd., Ste. E
Timonium, MD 21093
Mon - Fri: 8 am - 5 pm
410.252.4015
FAX: 410.252.7410

10 Landover
8700 Central Ave.
Landover, MD 20785
Mon - Fri: 8 am - 5 pm
301.499.4655
FAX: 301.499.0902