

THE HOWARD COUNTY PUBLIC SCHOOL SYSTEM
10910 Clarksville Pike
Ellicott City, Maryland 21042

Circular No. 43
Series 2015-2016

March 30, 2016

Chief Operating Officer

Procedures for Workers'
Compensation and
Employee Incident Reports

TO: All Staff

FROM Camille B. Jones, Chief Operating Officer

Attached please find a copy of the updated procedures for reporting a work-related injury/illness. Also, please find sample copies of the Workers' Compensation Commission First Report of Injury (Form IA-1) and Employee Incident Report, referred to in the procedures.

Please read the procedures thoroughly and, in particular, pay careful attention to what you must do when an employee assigned to your school/area is injured or assaulted. Please inform your staff of the procedures for reporting incidents and obtaining medical care. Failure to follow these procedures may impact the workers' compensation benefits received. The forms must be completed and forwarded to the Office of Safety, Environment, and Risk Management within 48 hours of the injury.

Additional forms are available from the Office of Safety, Environment, and Risk Management upon request and are also available on the Staff Hub under Services → Employee Resources → Workers' Comp & Incident Reports.

If you have any questions, please contact Terry Street at 410-313-6739 or Cathy McLin at 410-313-7494.

CBJ/TS/cm

Attachment

Howard County Public School System
10910 Clarksville Pike
Ellicott City, MD 21042

Workers' Compensation
Program and Procedures

TABLE OF CONTENTS

	Page
HCPSS Workers' Compensation Program	1-6
Procedures for Medical Attention (Work Related Injuries/Illness)	7- 8
Instructions – Incident Report Forms	9
W/C First Report of Injury or Illness (Form IA-1)	Exhibit A
Employee Incident Report	Exhibit B
Authorization for Treatment	Exhibit C

HCPSS WORKERS' COMPENSATION PROGRAM

Workers' Compensation is a program that provides benefits for an employee who sustains a compensable work related injury or illness while performing assigned job duties in the course of employment. All work related injuries/illnesses must be reported. Work related injuries/illnesses of employees are subject to the Maryland Workers' Compensation laws.

The Howard County Public School System (HCPSS) Workers' Compensation benefits and procedures are as follows:

1. Appropriate medical attention (first aid and/or professional medical care) will be provided immediately to an employee sustaining a work-related injury/illness. Professional medical care is provided through the following procedures:
 - a. **Call 911 immediately for a life-threatening injury/illness.** If the employee is not admitted to the hospital, the **employee is required** to report to Concentra Medical Center within 24 hours of treatment from the hospital. An Employer's Authorization for work evaluation and/or treatment is to be taken by the employee to the initial visit at Concentra Medical Center. This form is to be provided by the employee's site of employment (school or office).
 - b. **Non-emergency injury/illness.** The employee must report to Concentra Medical Center, 6656 Dobbin Road, Columbia, MD 21045, 410-381-1330 or Concentra Medical Center, 7377 Washington Boulevard – Suite 101, Jessup, MD 21075, 410-379-3051 for work evaluation and/or treatment. The employee will be given an Employer's Authorization for Examination or Treatment to take to the initial visit at Concentra Medical Center.
 - c. If it is a non-emergency injury/illness, and the employee requires professional medical care during the hours that Concentra Medical Center is closed, the employee may receive treatment from other medical services. The **employee is required** to report to Concentra Medical Center the next open business day for a work evaluation and/or treatment. The employee will be given an Employer's Authorization for Examination or Treatment to take to the initial visit at Concentra Medical Center.

NOTE: This does not bar the employee from seeking medical treatment from a physician or urgent care center of choice. However, only the work evaluation for work restrictions and off work status from Concentra Medical Center will be accepted, unless waived by the Office of Safety, Environment, and Risk Management.

2. All incidents must be reported by the employee to a supervisor immediately after the event. Any employee or individual aware of the incident may report the incident, if the injured/ill employee is unable to do so.

- a. Failure to notify a supervisor of an incident will be cause for forfeiture of compensation, unless excused by the Maryland Workers' Compensation Commission. The 90-day full salary benefit will be forfeited.
- b. An Employee Incident/Injury Report will be completed for all incidents as soon as possible, even those that do not require medical attention. This form serves as notification of the incident, should medical attention be required at a later date.
 - 1. The employee completes each question on Section I (front page), signs, dates the form, and returns it to the principal /supervisor/lead person.
 - 2. Section II is completed, signed, and dated by the principal/supervisor/lead person. All questions must be answered.
 - 3. Submit the completed, signed, original form to the Office of Safety, Environment, and Risk Management within 48 hours of the injury/illness or knowledge of the incident. If this is a serious injury/illness (911 or off work status), fax the form to 410-313-7177. Keep a copy for your file.
- 3. The Workers' Compensation First Report of Injury must be completed for all injuries that require medical attention and/or lost time from work.
 - a. **The principal/facility manager completes this form. The injured/ill employee does not complete or sign this form.**
 - 1. The principal or facility manager must sign and date.
 - 2. All sections except for wage information must be answered.
 - 3. Submit the completed, signed, original form to the Office of Safety, Environment, and Risk Management within 48 hours of the injury/illness or knowledge of the incident. If this is a serious injury/illness (911 or off work status), fax the form to 410-313-7177. Keep a copy for your file.
- 4. SISCO is the Workers' Compensation Third Party Claims Administrator for the Howard County Public School System.
 - a. SISCO will investigate and determine if the claim meets the criteria under Maryland state law for a compensable Workers' Compensation claim.
- 5. The injured/ill **employee** must **immediately notify** his/her principal/supervisor/lead person if he/she is placed off from work or needs to modify his/her job tasks.

- a. The employee must submit the Activity Status Report from Concentra Medical Center to his/her principal/supervisor/lead person for review of the work status and restrictions upon return from each visit to Concentra, or at the next scheduled workday.
 - b. The Activity Status Report will be reviewed and job tasks modified as per the work restrictions. The Activity Status Report from Concentra Medical Center is required by the Workers' Compensation claim administrator (SISCO), by the Office of Safety, Environment, and Risk Management, and by the employee's school/department for modified duty assignments.
 - c. The Office of Safety, Environment, and Risk Management is to be notified by the principal/facility manager when they are unable to modify an employee's job tasks at the employee's regular work site. The Office of Safety, Environment, and Risk Management will assign the employee to a modified duty position based upon the employee's restrictions, skills, and length of disability.
 - d. All employees of HCPSS are subject to modified duty assignments. Modified duty assignments are temporary short-term work assignments. Assignments are contingent upon medical status and needs of the school system.
 - e. Employees are required to provide information concerning work status and medical treatment as requested by the Office of Safety, Environment, and Risk Management.
 - f. When an employee returns to work, he/she must provide the supervisor and Office of Safety, Environment, and Risk Management with a Concentra doctor's certificate that verifies that the employee is able to return to work. The statement must include the date of return to work and any work restrictions, i.e., modified duty. **Note: The doctor must list those things the employee can and cannot do – "modified duty" is not enough.**
 - g. An employee receiving treatment from Concentra must schedule appointments before or after work hours, or as close to that time as possible.
6. **All time lost from work due to a work-related compensable injury/illness must be substantiated by the Activity Status Report from Concentra Medical Center.** During the period of disability, salary compensation will be as follows:
- a. No salary will be paid to the employee under Workers' Compensation until SISCO has determined that the claim is compensable.
 - b. The Activity Status Report from Concentra Medical Center is required by the Office of Safety, Environment, and Risk Management, and by the employee's school/department for payment of lost time from work.

- c. If not documented by the Activity Status Report from Concentra Medical Center, time lost from work will be charged to accrued leave, or if none, leave without pay. Compensable lost time will be paid at the rate specified by Maryland Workers' Compensation law.
- d. Failure to substantiate time away from work by Concentra Medical Center is a forfeiture of benefits for full pay under the HCPSS 90-day benefit. It is not a denial of a Workers' Compensation claim or any compensation due under the Workers' Compensation law.

NOTE: Employees covered by negotiated agreements, meet and confer agreements and Administrative Management are eligible for salary benefits under the 90-day benefit. Temporary and non-benefited employees are not eligible for this benefit.

- 7. If the employee is unable to return to work due to a compensable work related injury/illness, HCPSS will pay eligible employees full salary for a period not to exceed 90 workdays without loss of annual, sick, or personal leave or fringe benefits for the employee. The availability of the 90 days expires one year from the date of the injury/illness.
 - a. Subject to employee eligibility, a period of incapacity of five or more days will be considered a serious health condition, as defined by the Family and Medical Leave Act (FMLA). Days will be counted under an employee's annual FMLA entitlement (12 weeks/60 working days) and run concurrently with Workers' Compensation.
 - b. During the 90-day period, an employee will be paid at the rate of pay the employee is earning at the time leave is taken.
 - c. Employees will be paid for lost wages if time away from work is for an independent medical examination at the request of SISCO or HCPSS.
 - d. Failure to use provided safety equipment, or improper use of equipment and materials, may result in loss of eligibility for full salary benefits under the 90-day benefit.
 - e. A claim resulting from an employee's willful misconduct is subject to denial under the Maryland Workers' Compensation law.
- 8. After the 90-day period expires, and the employee has not returned to work, the employee has the option to use accrued leave to make up the difference between Workers' Compensation benefits and his/her full regular salary in order to continue to receive full salary payments. If the employee elects not to use accrued leave, or if none is available, the employee will be placed on an approved leave of absence without pay and will continue to receive any Workers' Compensation benefits to which he/she is entitled.

- a. Any salary payments made by SISCO to the employee, not applicable to the 90-day period, will belong to the employee.
 - b. Subject to FMLA qualifications, an employee may return to the same or substantially equivalent position and location within 12 weeks (60 working days) of the work related injury/illness. If the employee is not able to return to work within the 12 week time (FMLA) period (including the 90-day period), the employee will be assigned to a same or equivalent position when a vacancy becomes available for which the employee is qualified. The employee will be placed at the grade and step held at the time of injury, or if placed in an equivalent position an appropriate grade and step for that position. Pay increments occurring during an employee's time away from work are subject to approval by the Human Resources Office.
 - c. After an absence of six months (including the 90-day period), the employee will be placed on an excused leave of absence for a period up to two years, including the 90-day and subsequent absences. The employee may use any accrued leave.
 - d. The approved leave of absence will not affect any benefits that may be due under the Workers' Compensation law.
9. The Department of Human Resources will be notified when the 90-day period expires or other circumstances require consideration for a leave of absence and when the employee is placed on an approved leave of absence.
10. If SISCO has determined that the injury/illness is a non-compensable claim, then:
- a. If the employee is not able to return to work, he/she may use accrued leave, if available, and apply for a leave of absence for the duration of the recovery period. Leave is subject to FMLA.
 - b. If leave is not available, then the employee must apply for an unpaid leave of absence for the duration of the recovery period. Leave is subject to FMLA.
 - c. Reassignment will be determined by the Department of Human Resources.
 - d. All time lost from work will be charged to the employee's accrued leave, and if none, the employee will be placed in a no-pay status.
 - e. SISCO will notify the employee when a claim has been denied. The employee may appeal this decision by filing a Notice of Employee Claim Form with the Maryland Workers' Compensation Commission.
11. If the employee is physically injured in the scope of his/her employment as the result of an assault and is absent due to physical disability that results from the assault, the employee will be kept on full pay status instead of sick leave during the period of

absence. In this case, the following will apply:

- a. Assault is defined as a willful, unprovoked attack intended to do harm to another that results in a physical disability.
- b. The employee must immediately notify their supervisor of the incident and injury.
- c. The employee is required to complete the Employee Incident Report of Injury/Illness and completely describe the incident and why it is considered an assault.
- d. HCPSS will file a Workers' Compensation 1st Report of Injury reporting the incident and injury.
- e. Procedures for the 90-day full salary benefit are followed to include certification from the Concentra medical provider of the employee's disability.
- f. If the employee's disability extends beyond the 90-day full salary benefit, then assault leave may apply. Assault leave is paid leave provided in accordance with §6-111 of the Education Article of Maryland Statute.
- g. The employee will submit medical documentation from a licensed physician to SISCO, the HCPSS TPA, for determination of any Workers' Compensation temporary total benefits that may be due.
- h. If SISCO determines that temporary total benefits are due, then the employee will receive Assault leave in lieu of temporary total benefits with no sick leave charged.
- i. FMLA will run concurrent with Assault Leave.
- j. HCPSS may require a medical examination conducted by a physician selected and paid for by HCPSS.
- k. Only permanent employees are eligible for Assault Leave.
- l. Assault leave will end when the employee returns to work, temporary total benefits end, and/or if the employee retires.
- m. HCPSS may require the employee apply for disability retirement.

Contact the Office of Safety, Environment, and Risk Management at 410-313-6739 or 410-313-7494 with any questions.

PROCEDURES FOR MEDICAL ATTENTION WORKERS' COMPENSATION

EMERGENCY INJURY/ILLNESS

An employee sustaining a work-related injury/illness that requires emergency assistance (911 or use of an ambulance) shall:

- Call 911 immediately for life-threatening injury/illness.
- Contact next of kin, spouse, or emergency contact person.
- Report all 911 calls to the Office of Safety, Environment, and Risk Management (410-313-6739/7494).
- Unless admitted to the hospital, the employee must report to Concentra on the next business day for work evaluation and/or treatment.
- Follow procedures under Non-Emergency Injury/Illness after visit to Concentra.

NON-EMERGENCY INJURY/ILLNESS

An employee sustaining a work-related injury/illness that does not require emergency medical care (911) shall:

- Obtain an Employer's Authorization for Examination or Treatment at Concentra Medical Center from his/her principal/supervisor/lead person.
- Employee must report for work evaluation and/or treatment at Concentra Medical Center (any location).
- Each employee will receive an Activity Status Report at the conclusion of each visit to Concentra.
- Employee shall return the Activity Status Report to the principal or designated staff, supervisor, or lead person for review of work status and restrictions.
- The Activity Status Report shall be reviewed, and job tasks modified as per the work restrictions.
- Notify the Office of Safety, Environment, and Risk Management if unable to modify the job tasks at the employee's regular work site, or if the employee is placed in an off work status.
- The Office of Safety, Environment, and Risk Management will assign the employee to a modified duty position based upon the employee's restrictions, skills, and length of disability.
- All employees may be assigned to modified duty assignments.

The Activity Status Report from Concentra Medical Center must substantiate all time away from work due to a work-related injury/illness. The Activity Status Report is given to the employee at the conclusion of each visit to Concentra Medical Center. This report must be given to the employee's principal/supervisor/lead person for review of the work status and restrictions upon return from the visit to Concentra Medical Center, for review of any necessary job modifications to accommodate work restrictions.

Failure to substantiate time away from work from Concentra Medical Center is a forfeiture of benefits for full pay under the 90-day policy of HCPSS. It is not a denial of a

Workers' Compensation claim or any compensation due under the Workers' Compensation law.

Concentra Locations in and near Howard County

6656 Dobbin Road
Columbia, MD 21045

410-381-1330 Fax 410-381-5585

7377 Washington Blvd.

Jessup, MD 21075

410-379-3051 Fax 410-379-3074

Both locations are open 8:00 am – 5:00 pm Monday through Friday.

INSTRUCTIONS FOR WORKERS' COMPENSATION FORMS

Employer's Authorization for Examination or Treatment at Concentra Medical Center

- Principal/supervisor/lead person should complete and sign the authorization to include employee name, date of birth, school/department name, date of injury, purpose of visit (work-related injury or illness), signature and title of person completing the form.
- Employee is to take the completed authorization form to the initial visit at Concentra Medical Center and give it to the receptionist upon arrival.

Employee Incident/Injury Report

- Completed for all incidents, even those that do not require medical attention. Should medical attention be required at a later date, this form serves as notification of the occurrence of the incident.
- Employee completes each question on Section I (front page), signs, dates the form and returns the form to their principal/supervisor/lead person.
- Section II (back page) is to be completed, signed, and dated by the principal/supervisor/lead person.
- All questions must be answered.
- Submit the completed, signed, and dated original form to the Office of Safety, Environment and Risk Management within 48 hours of the injury/illness or knowledge of the incident.
- Fax the form if this is a serious injury/illness (911 or off work status) to 410-313-7177. Keep a copy for your file.

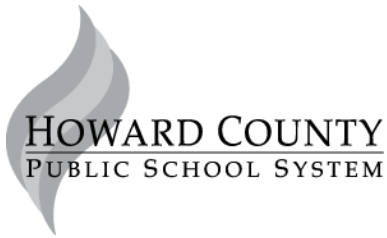
Workers' Compensation First Report of Injury or Illness

- Completed for all incidents that require medical attention and/or lost time from work.
- Completed by the principal/supervisor/lead person. **The injured employee does not complete or sign this form.** The principal/supervisor/lead person must sign and date.
- All sections, **except for wage information**, must be answered.
- Submit the completed, signed, and dated original form to the Office of Safety, Environment, and Risk Management within 48 hours of the injury/illness or knowledge of the incident.
- Fax the form if this is a serious injury/illness (911 or off work status) to 410-313-7177. Keep a copy for your file.

Please give the injured/ill employee the pamphlet "Workers' Compensation for Employees of the Howard County Public School System".

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

GENERAL	EMPLOYER (NAME & ADDRESS INCL ZIP)			CARRIER/ADMINISTRATOR CLAIM NUMBER		REPORT PURPOSE CODE				
	Howard County Public School System 10910 Clarksville Pike Ellicott City, MD 21042			JURISDICTION		JURISDICTION CLAIM NUMBER				
				INSURED REPORT NUMBER						
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)			LOCATION #		PHONE #				
SIC CODE	EMPLOYER FEIN 52-60000968						(410) 313-6600			
CARRIER ADMINISTRATOR	CARRIER (NAME, ADDRESS & PHONE NO)			POLICY PERIOD		CLAIMS ADMINISTRATION (NAME, ADDRESS & PHONE NO)				
	Self Insured			TO		SISCO RCM&D Self-Insured Services, Co, Inc. 555 Fairmount Avenue Baltimore, MD 21286-5497 (410) 339-7263				
				CHECK IF APPROPRIATE <input checked="" type="checkbox"/> SELF INSURANCE						
	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	
	ADDRESS (INCL ZIP)			SEX		MARITAL STATUS		OCCUPATION/JOB TITLE		
	TELEPHONE (INCLUDE AREA CODE)			M MALE		U UNMARRIED (SINGLE/DIVORCED)		EMPLOYMENT STATUS		
				F FEMALE		M MARRIED		NCCI CLASS CODE		
			U UNKNOWN		S SEPARATE					
			K UNKNOWN							
WAGE	RATE			# DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY?		YES	NO	
	PER:	DAY	MONTH			DID SALARY CONTINUE?		YES	NO	
OCCURRENCE	TIME EMPLOYEE BEGAN WORK		AM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE		AM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
			PM				PM			
	CONTACT NAME/PHONE NUMBER				TYPE OF INJURY/ILLNESS				PART OF BODY AFFECTED	
	DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES?				TYPE OF INJURY/ILLNESS CODE				PART OF BODY AFFECTED CODE	
	YES				NO					
	DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED				ALL EQUIPMENT, 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 THE 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 SAFEGAURDS OR SAFETY EQUIPMENT PROVIDED?				YES	NO
					WERE THEY USED?				YES	NO
TREATMENT	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 HOURS 5 FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED			
OTHER	WITNESS (NAME & PHONE #)									
	DATE ADMINISTRATOR NOTIFIED		DATE PREPARED		PREPARER'S NAME & TITLE (Princ/Supvr's Signature)				PHONE NUMBER	



**OFFICE OF SAFETY, ENVIRONMENT AND RISK
MANAGEMENT**

Terry_Street@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 7/15



(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

Special instructions/comments: _____

Authorized by: _____

Please print

Phone: (_____) _____

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

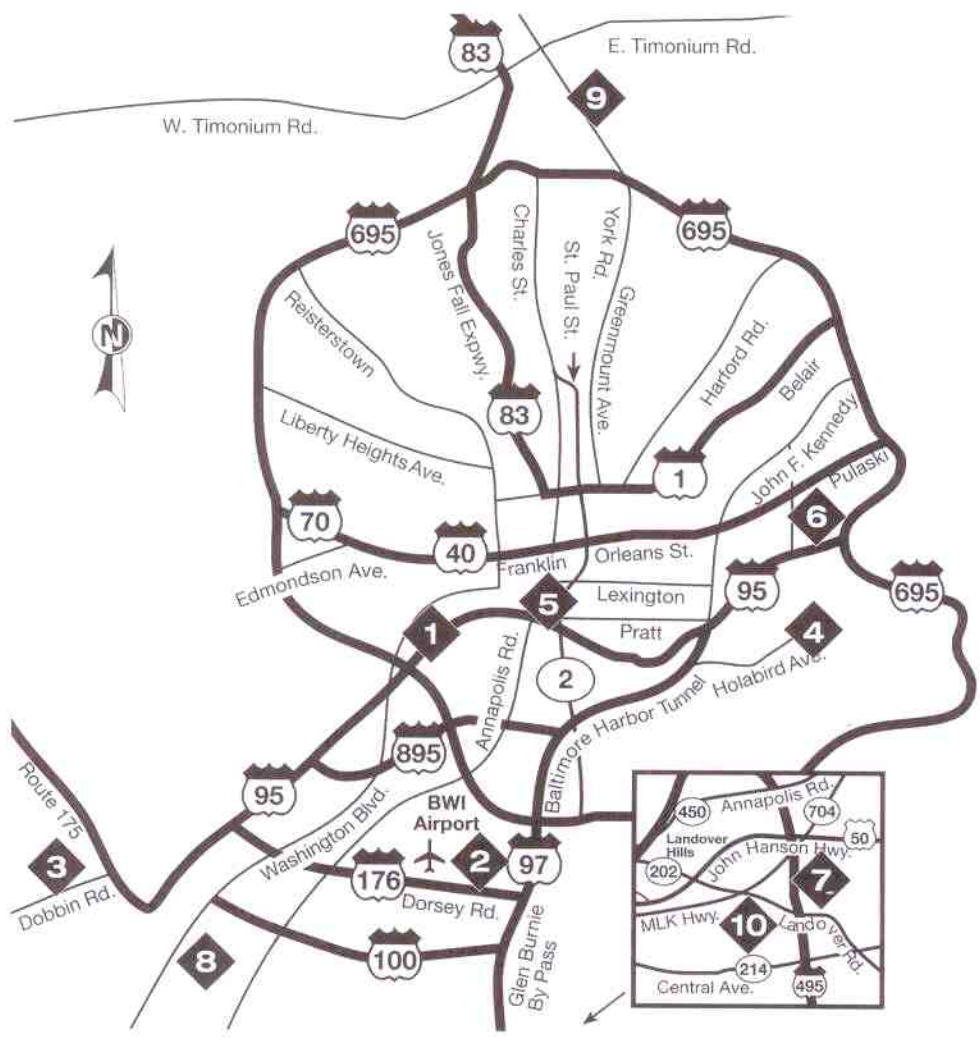
★ Due to the nature of these specific services, only the patient and staff are allowed in the testing/treatment area. Please alert your employee so that they can make arrangements for children or others that might otherwise be accompanying them to the medical center.

Title: _____

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)



- 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