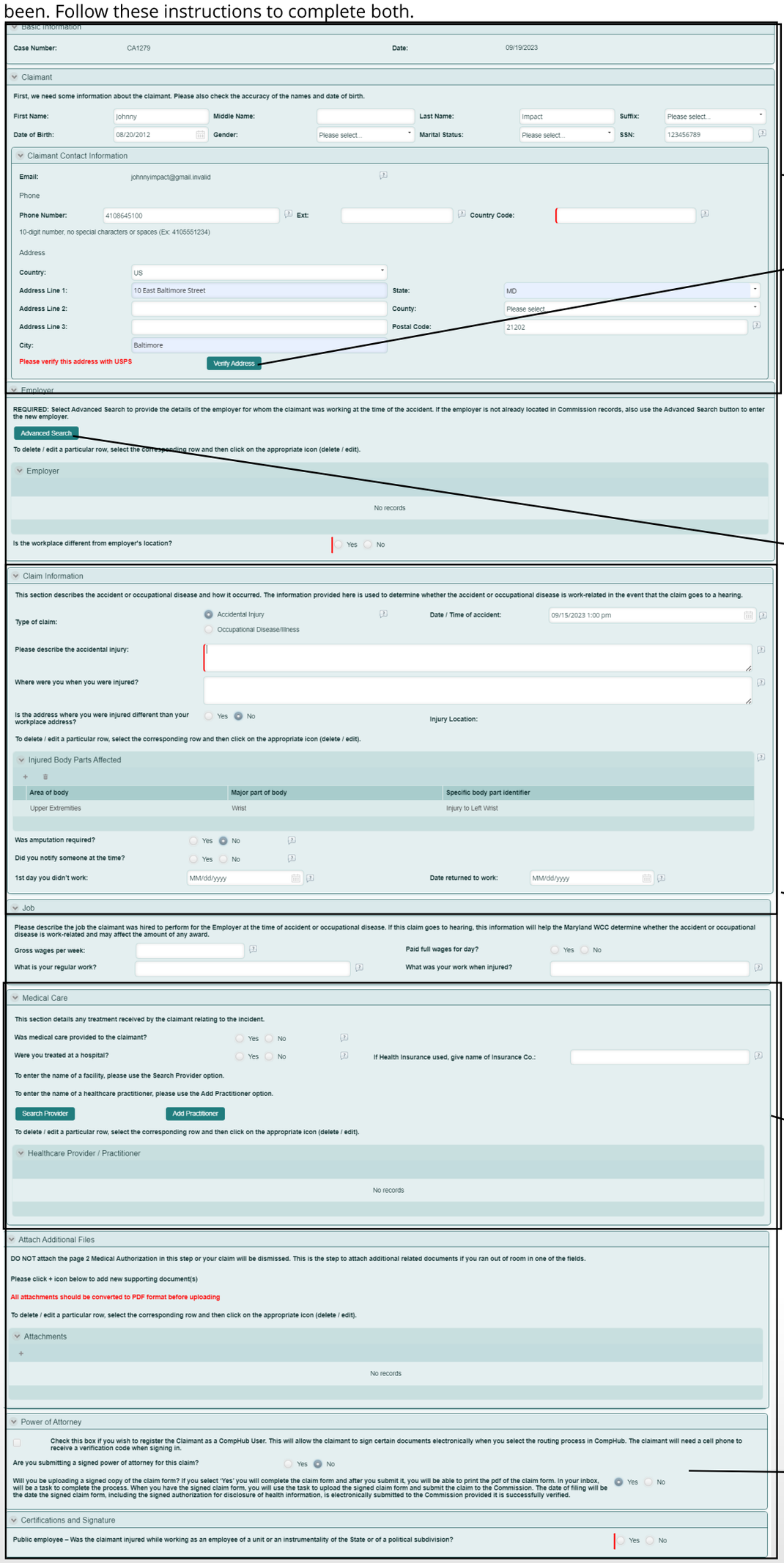
Initial Claim - Attorney

The Initial Claim form is the precursor to much of what happens in CompHub and Workers' Compensation claims in the State of Maryland as a whole. This form can be completed completely in the application or printed and signed just like it always has been. Follow these instructions to complete both.



1 *The basic Claimant Information is entered on the Start Form. Any information entered in the Address section should be verified by Clicking/Tapping Verify address.*

2 *Search for an Employer by clicking Advanced Search, if the Employer is not already in Commission records you can also request the employer be added. If the workplace is different then the employer's registered location you will need to enter that address.*

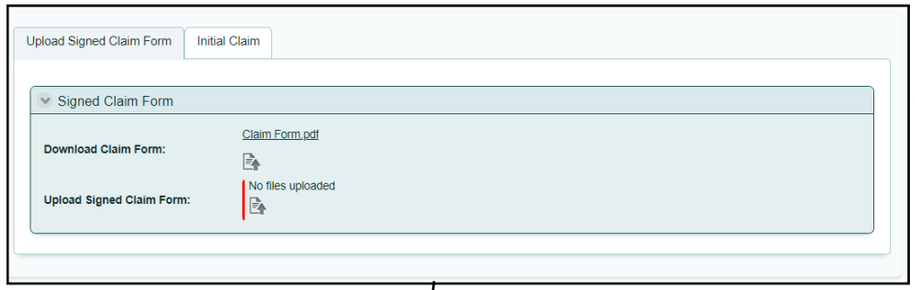
3 *Enter the accident/illness description and add the body parts in the Claim Information section.*

4 *Enter any Medical Information in the Medical Care section. Providers and Practitioners are searched/requested for the same way as Employers. Add Any supporting Documentation with a brief concise description (e.g. Discharge Summary*

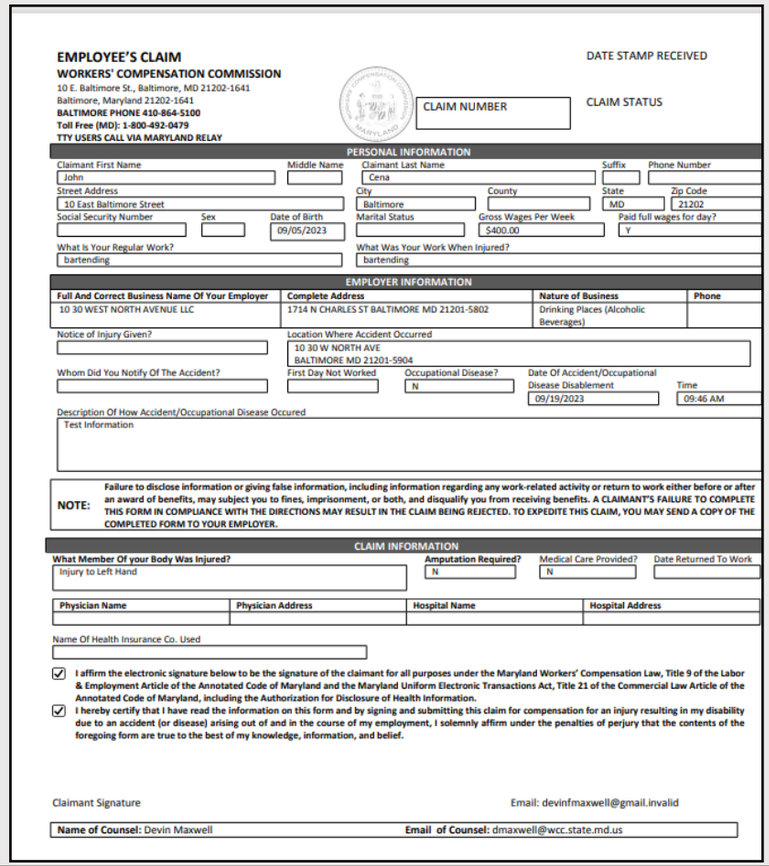
5 *Electronic: Attach the signed power of attorney and Sign. To Upload the Claim Form: Complete steps 1-4 and select No for POA and 'Yes' for the upload option. CompHub will generate the Claim Form and Med. Auth with a blank line for signature.*

Initial Claim - Attorney

Uploading the Form



1 *Click "Claim Form" to download the Form. I recommend renaming the file to something easy to identify.*



EMPLOYEE'S CLAIM
WORKERS' COMPENSATION COMMISSION
10 E. Baltimore St., Baltimore, MD 21202-1641
Baltimore, Maryland 21202-1641
BALTIMORE PHONE 410-864-5100
Toll Free (MD): 1-800-492-0479
TTY USERS CALL VIA MARYLAND RELAY

DATE STAMP RECEIVED
CLAIM NUMBER
CLAIM STATUS

PERSONAL INFORMATION

Claimant First Name	Middle Name	Claimant Last Name	Suffix	Phone Number
John		Cena		

Street Address	City	County	State	Zip Code
10 East Baltimore Street	Baltimore		MD	21202

Social Security Number	Sex	Date of Birth	Marital Status	Gross Wages Per Week	Paid full wages for day?
		09/05/2023		$400.00	Y

What Is Your Regular Work?	What Was Your Work When Injured?
bartending	bartending

EMPLOYER INFORMATION

Full And Correct Business Name Of Your Employer	Complete Address	Nature of Business	Phone
10 30 WEST NORTH AVENUE LLC	1714 N CHARLES ST BALTIMORE MD 21201-5802	Drinking Places (Alcoholic Beverages)	

Notice of Injury Given?
Location Where Accident Occurred: 10 30 W NORTH AVE BALTIMORE MD 21201-5904

Whom Did You Notify Of The Accident?	First Day Not Worked	Occupational Disease?	Date Of Accident/Occupational Disease Disablement	Time
		N	09/19/2023	09:46 AM

Description Of How Accident/Occupational Disease Occured: Test Information

NOTE: **Failure to disclose information or giving false information, including information regarding any work-related activity or return to work either before or after an award of benefits, may subject you to fines, imprisonment, or both, and disqualify you from receiving benefits. A CLAIMANT'S FAILURE TO COMPLETE THIS FORM IN COMPLIANCE WITH THE DIRECTIONS MAY RESULT IN THE CLAIM BEING REJECTED. TO EXPEDITE THIS CLAIM, YOU MAY SEND A COPY OF THE COMPLETED FORM TO YOUR EMPLOYER.**

CLAIM INFORMATION

What Member Of your Body Was Injured?	Amputation Required?	Medical Care Provided?	Date Returned To Work
Injury to Left Hand	N	N	

Physician Name	Physician Address	Hospital Name	Hospital Address

Name Of Health Insurance Co. Used

☑ **I affirm the electronic signature below to be the signature of the claimant for all purposes under the Maryland Workers' Compensation Law, Title 9 of the Labor & Employment Article of the Annotated Code of Maryland and the Maryland Uniform Electronic Transactions Act, Title 21 of the Commercial Law Article of the Annotated Code of Maryland, including the Authorization for Disclosure of Health Information.**
☑ **I hereby certify that I have read the information on this form and by signing and submitting this 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, I solemnly affirm under the penalties of perjury that the contents of the foregoing form are true to the best of my knowledge, information, and belief.**

Claimant Signature
Email: devinfmaxwell@gmail.invalid

Name of Counsel: Devin Maxwell
Email of Counsel: dmaxwell@wcc.state.md.us

2 *Once you've obtained the signatures, click the upload Icon to. upload the signed copy. The submission date will be the date this task is completed.*

If you need to come back to upload the form, don't worry; you can come back to the "Upload Signed Claim Form" task for your claim. and upload the signed copy.