



2401 York Road
Timonium, MD 21093
Phone (410) 321.4267
Fax (410) 321.4980

Incident Report Form

Printed Employee Name: _____ Certification _____

Are you reporting an incident or on-the-job injury ?

Address and Specific Location of incident/injury: _____

_____ Unit: _____

Date and time of incident/injury: _____

- Describe the incident/injury in detail: (including events that occurred immediately before)

- If applicable, identify bodily injury sustained: _____

- Was a patient involved in incident? _____ If so, name of patient: _____

- First and last name of on-site supervisor at time of incident/injury: _____

- Full name(s) and address(es) of witness(es): _____

- To whom did you report the incident: _____

- Did you seek medical attention: Yes: _____ No: _____ Not at this time: _____

- Name of treating physician: _____ Phone #: _____

The incident report must be completed and faxed to the CMS office within 24 hours of the incident.

If applicable for employee injury, once your incident/injury report has been reported to Workman's Compensation, you will be assigned a claim number. Using your Workman's Compensation claim number and your social security number, you can obtain prescriptions through your pharmacy, who will bill Express Scripts (Workman's Compensation Insurance Fund) directly. You will not have to pay out-of-pocket for prescriptions.

Any bills or invoices that you may receive due to the incident/injury should to be forwarded to CMS Human Resources office. The actual invoice may be necessary for reimbursement from our insurance company, so please keep all original bills and receipts. Please contact CMS if you have any questions.

Signature of Employee: _____ Date: _____

Signature of CMS Manager: _____ Date Received: _____