Worker’s Compensation Insurance Information

Provide the following information in compliance with the Labor and Employment Article, §9-201 et seq., Annotated Code of Maryland.

Is there anyone at your facility who provides care or assistance at your direction?  □ Yes  □ No

If the answer is NO, sign and date the form, and return it with your application.

If the answer is YES, check (A) or (B) below and complete the information needed. Then sign and date the form and return it with your application.

IF YOU ANSWERED YES, YOU MUST:

□ A) Attach a copy of your Worker’s Compensation Insurance Policy statement page. It must show the effective and expiration dates.

Or

□ B) Complete the information below about your Worker’s Compensation Commission policy or binder number.

1) Policy or Binder Number:___________________________________________

2) Insurance Company: _______________________________________________

3) Effective Date: ____________________________________________________

4) Expiration Date: ______________

Signature: _______________________________________________________________________
Title: ___________________________________________________________________________
Date: __________________________________________
County: _________________________________________________________________________
Name of Center: __________________________________________________________________

If you have questions about Workman’s Compensation, contact your insurance carrier or Workman’s Compensation Commission.

OCC 1201- Revised 12/15 - All previous editions are obsolete.