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DELAWARE
Workers' Compensation
Key Forms and Dates

State of Delaware
Workers' Compensation
Key Forms and Dates

1. First Report of Injury (Exhibit 1)
   - Filed by Employer within 10 days of notice of an alleged work related injury.
   - Filed regardless of whether the employee subsequently makes a claim.
   - Not to be used as evidence at a hearing.
   - Claims must be acknowledged or denied in writing within 15 days of notice of the claim.
2. Agreement as to Compensation (Exhibit 2)
   - Required to be filed when any benefits have been paid – medical or indemnity.
   - Official acknowledgement of a compensable injury
   - Sets AWW and Compensation Rate
3. Agreement for Compensation For Death (Exhibit 3)
   - Must be filed when benefits are sought by dependents following a compensable work-related death claim.
4. Receipt for Compensation Paid (Exhibit 4)
   - Must have a signed receipt to stop paying temporary total or partial disability benefits.
   - Filed with the Agreement for lump sum benefits such as permanent impairment.
5. Physician's Report of Worker's Compensation Injury (Exhibit 5)
   - Form completed by the claimant's treating doctor(s) noting diagnosis, treatment rendered and plan, and disability or work capabilities.
   - Must be completed on initial presentation and thereafter upon a material change in the claimant's condition which impacts work capability. In addition, a report must be provided on discharge of the patient.
   - Physician paid a straight $30 report fee for completing these forms (not subject to the fee schedule).
   - Physician subject to a fine for failure to complete and submit these forms.
   - Must be submitted to the employee, employer and carrier, not later than 10 days after the initial visit.
6. Employer's Modified Duty Availability Report (Exhibit 6)
   - Following issuance of "Agreement as to Compensation" for total disability benefits, the employer must provide this completed form to the doctor and employer's insurance carrier within 14 days. Provider must then return the completed form within 21 days from receipt.
   - Insurance carrier is responsible for sending this form to the employer and the completed form to the doctor.
7. Request for Utilization Review (Exhibit 7)
   - Must be filed in order to challenge treatment subject to the Health Care

Practice Guidelines in an acknowledged claim.

- UR not required if the denial is based on causal relationship.
- Carrier must deny or pay a compensable bill within 30 days.
- Carrier has 15 days from the date of denial to file the UR with the DOL.
- Either party may appeal the UR decision 45 days from receipt of UR Determination.

8. Pharmacy Justification Form (Exhibit 8)
   - Doctor must complete this form with the prescription to dispense non-preferred/brand name drug or medication per 19 DE Admin. Code 1342, Section 4.13.
9. Stipulation and Petition for Commutation of Benefits (Exhibit 9)
   - Filed together with a stipulation and order for Board approval of lump sum or full and final settlements.
   - Attach Medicare Set Aside analysis and any annuity plans, if applicable.
   - Claimant's attorney must include fee agreement and disbursement sheet.
10. Request for Copy of Industrial Accident Board file (Exhibit 10)
11. Petitions (Collectively Exhibit 11)
    - Petition to Determine Compensation Due (DCD)
      - Initial petition filed by Claimant for compensability.
      - Filed with a Statement of Facts detailing the alleged accident and injuries.
      - Hearings to be held within 120 days of the Pretrial Conference.
    - Petition to Determine Compensation Due to Dependents of Deceased Employee
    - Petition to Determine Additional Compensation Due (DACD)
      - Petition filed after claim determined compensable for any subsequent benefits - i.e. recurrence of TTD, denied treatment, permanency benefits.
      - Hearings held within 180 days of the Pretial Conference.
    - Petition to Determine Disfigurement
      - Used for hearing to view scarring claim.
      - Hearings scheduled on motion days.
    - Petition to Review Compensation Agreement
      - Also referred to as Termination Petition.
      - Used by carrier to terminate wage loss benefits or review an Agreement.
      - Cannot be filed more often than once every six months.
      - Hearings held within 120 days of the Pretrial Conference.
    - Petition to Appeal a Utilization Review
      - Filed by either party within 45 days of receipt of UR.
12. Agreement by Executive Officer(s)/LLC Member(s) not to be subject to the Delaware Workers' Compensation Law. (Exhibit 12)

Most forms available in “fillable” PDF format on the Department of Industrial Affairs’ web site: https://dia.delawareworks.com/workers-comp/forms.php and https://dowc.optum.com/info.asp?page=forms

Exhibit 1

ALL COPIES OF THIS FIRST REPORT MUST BE TYPED OR PRINTED

Department of Labor
Office of Workers' Compensation (OWC)
4425 N. Market Street
Wilmington, DE 19802
Telephone 302-761-8200

STATE OF DELAWARE
FIRST REPORT
OF OCCUPATIONAL INJURY OR DISEASE

OWC Case File No. _____

ALL INFORMATION IS REQUIRED, unless not applicable where "if applicable" is noted.

1. EMPLOYEE: FIRST MIDDLE LAST		**2. EMPLOYEE SOCIAL SECURITY NO.**	
3. ADDRESS – INCLUDE COUNTY AND ZIP CODE		**4.** MALE ☐ FEMALE ☐	**5. EMPLOYEE PHONE NUMBER (INCLUDING AREA CODE)**
6. DATE OF BIRTH / /	**7. AGE**	**8. WAGE**	**9. WEEKLY HOURS WORKED**
10. OCCUPATION (REGULAR)	**11. DEPARTMENT OR DIVISION REGULARLY EMPLOYED**		**12. HOW LONG EMPLOYED**
13. EMPLOYER:		**14. PERSON MAKING OUT THIS REPORT**	
15. ADDRESS – INCLUDE COUNTY AND ZIP CODE		**16. EMPLOYER PHONE # (INCLUDE AREA CODE)**	
17. MAILING ADDRESS – IF DIFFERENT THAN ABOVE		**18. NATURE OF BUSINESS – TYPE OF MFG., TRADE, CONSTURCTION, SERVICE, ETC.**	
19. WORKERS' COMPENSATION INSURANCE CARRIER		**20. WORKERS' COMP. INS. CARRIER PHONE #, (INCLUDING AREA CODE**	
21. WORKERS' COMP. INSURANCE CARRIER ADDRESS		**22. POLICY NUMBER / CARRIER CASE NUMBER:** /	
23. THIRD PARTY ADMINISTRATOR (TPA), IF APPLICABLE	**24. TPA ADDRESS – INCLUDE CITY STATE AND ZIPCODE**		

DATES: **25. DATE OF REPORT** / /	**26. DATE OF INJURY** / /	**27. NORMAL STARTING TIME** ☐ AM ☐ PM	**28. IF EMPLOYEE BACK TO WORK GIVE DATE** / /	**29. AT SAME WAGE?** YES ☐ NO ☐
30. IF FATAL INJURY, GIVE DATE OF DEATH / /	**31. DATE EMPLOYER KNEW OF INJURY** / /	**32. DATE DISABILITY BEGAN** / /	**33. LAST FULL DAY PAID-DATE** / /	

INJURY OR DISEASE:

34. DESCRIBE THE INJURY/ILLNESS AND PART OF BODY AFFECTED.

35. SPECIFY THE DEPARTMENT WHERE INCIDENT OCCURRED AND THE WORK PROCESS INVOLVED.

OCCURRENCE:

36. LIST THE EQUIPMENT, MATERIALS, AND CHEMICALS EMPLOYEE USED WHEN THE INCIDENT OCCURRED, E.G. ACETYLENE.

37. DESCRIBE THE EMPLOYEE'S ACTIVITY AT THE TIME OF INJURY OR ILLNESS, E.G. LIFTING A PATIENT.

38. DESCRIBE HOW THE INJURY/ILLNESS OCCURRED.

39. NAME OF PHYSICIAN (IF APPLICABLE)	**40. PHYSICIAN'S ADDRESS**
41. HOSPITAL (IF APPLICABLE)	**42. HOSPITAL ADDRESS**

DISTRIBUTION OF THIS REPORT (1 original and 3 copies)

1. **ORIGINAL MUST BE SENT IMMEDIATELY TO THE WORKERS' COMPENSATION INSURANCE CARRIER.**
2. **COPY TO THE OFFICE OF WORKERS' COMPENSATION (use the address at the top left of this form)**
3. **EMPLOYER'S COPY – RETAIN AS RECORD**
4. **EMPLOYEE'S COPY**

WORKERS' COMPENSATION

IMPORTANT THINGS TO DO IN CASE OF INJURY

THE EMPLOYER SHOULD:

1. Provide all necessary medical, surgical and hospital treatment from the date of accident.
2. Every employer shall keep a record of all injuries received by employees and make a report within 10 days thereof in writing to the Office of Workers' Compensation.
3. Ascertain the average weekly wages of the employee and provide compensation in accordance with the provisions of the law, for disability *beyond the third day* after the accident. All agreements as to compensation must be submitted to the Office of Workers' Compensation for approval.

THE EMPLOYEE SHOULD:

1. Immediately notify the employer in writing of accidental injury or occupational disease and request medical services. Failure to give notice or to accept medical services may deprive the employee of the right to compensation.
2. Give promptly to the employer, directly or through a supervisor, notice of any claim for compensation for the period of disability beyond the third day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person on their behalf.
3. In case of failure to reach an agreement with the employer in regard to compensation under the law, file application with the Industrial Accident Board for a hearing on the matters at issue within two years of the date of accidental injury or one year of knowledge of the diagnosis of an occupational disease or an ionizing radiation injury. All forms can be obtained from the Office of Workers' Compensation.

Exhibit 2

CASE FILE NO. _____

CARRIER FILE NO. _____

STATE OF DELAWARE
OFFICE OF WORKERS' COMPENSATION
AGREEMENT AS TO COMPENSATION PAID

Employee _____ Employer _____

Address _____ Address _____

_____ _____

_____ _____

Insurance Carrier/Self-insurer _____ Third party adjuster _____

Address _____ Address _____

_____ _____

_____ _____

The above have reached an agreement in regard to compensation for the injury sustained by said employee and submit the following statement of facts relative thereto:

Date of Injury _____ Date Disability Began _____

Cause/Place of Accident _____

Nature/Part of Body _____

_____

Probable Length of Disability (if known) _____

The terms of this agreement under the above facts are as follows:

This agreement is for (check all that apply) _____ Total Disability _____Temporary Partial Disability

_____ Permanent Partial Disability _____ Disfigurement _____ Commutation _____ Medical Only

_____ Salary in Lieu of Workers' Compensation

That the said _____ shall receive compensation at the rate of

$_____ per week based upon an average weekly wage of $ _____ and that said compensation shall be

payable _____ weekly _____ bi-weekly _____ monthly _____ other (specify) from and including the _____ day of

_____ month _____ year until terminated in accordance with the provisions of the Workers' Compensation

Law of the State of Delaware.

See reverse side

BENEFITS FOR TOTAL/PARTIAL DISABILITY, (LOST WAGES) SHALL REQUIRE YOU TO ADVISE THE NAMED CARRIER/SELF-INSURER/THIRD PARTY ADJUSTER OF ANY CHANGES IN EMPLOYMENT STATUS AND/OR DISABILITY. FAILURE TO NOTIFY A CHANGE IN STATUS IS PUNISHABLE PURSUANT TO TITLE 18, DELAWARE CODE, CHAPTER 24, AND/OR TITLE II, DELAWARE CODE, SECTION 913.

Witness _____ Employee _____
(signature) (signature)

Address _____

_____

Adjuster/Attorney _____
(signature)

Phone number _____

Date of agreement _____

PURSUANT TO 19 *DEL. C.* §2322E(d), THE "EMPLOYER'S MODIFIED DUTY AVAILABILITY REPORT" SHALL ACCOMPANY THIS AGREEMENT AND THE COMPLETED REPORT SHALL BE FORWARDED TO THE HEALTHCARE PROVIDER/PHYSICIAN MOST RESPONSIBLE FOR TREATMENT WITHIN 14 DAYS. THE INSURANCE CARRIER FOR AN INSURED EMPLOYER SHALL BE INDEPENDENTLY RESPONSIBLE FOR PROVIDING A COMPLETED REPORT OF MODIFIED-DUTY JOBS TO THE PROVIDER/PHYSICIAN.

For Accounting Use Only:

Approved by _____

Date of Approval _____

Exhibit 3

FORM 18 Agreement No. _____

INDUSTRIAL ACCIDENT BOARD

State of Delaware

AGREEMENT FOR COMPENSATION FOR DEATH

(Memorandum of this Agreement must be filed with the Board)
(SECTION 107)

We the undersigned, being all the dependents who are entitled to compensation on account of the death of

_____

from a personal injury sustained by him or her by an accident arising out of and in the course of his or her employment and

_____

in whose service the said _____

was employed at the time of said injury, have reached an agreement in regard to the compensation to be paid by said employer.

Date of accident _____

Place of accident _____

Cause of injury _____

Nature of injury _____

Date of Death _____

The terms of the agreement under the above facts are as follows:

That the compensation payable shall be at the rate of $_____per week, based upon an average weekly wage of $_____at the time of said injury and shall be paid from the_____day of_____, 20____, until terminated, to the following person, or persons, or their legal representative, in accordance with the provisions of the "Delaware Workmen's Compensation Law of 1917," as amended and in the amount herein designated.

_____ $_____per week

_____ $_____per week

_____ $_____per week

_____ $_____per week

_____ $_____per week

Dated this_____day of_____, 20_____.

Witness: _____

_____

_____

_____

_____

_____

_____

_____ Signature of Dependents

_____

Signature of Employer

By_____

Authorized Agent

Exhibit 4

CASE FILE NO. _____

CARRIER FILE NO. _____

STATE OF DELAWARE

OFFICE OF WORKERS' COMPENSATION

RECEIPT OF COMPENSATION PAID

DATE _____

Received of _____
(Insurance Carrier/Self-Insurer/Third Party Adjuster)

the sum of $_____, making in all the total sum of $ _____

in settlement of compensation due for the_____disability of
(type)

_____ which began
(employee name)

on_____, and terminated on_____.
(date) (date)

_____
Employee Signature

_____
Address

_____

Your signature on this receipt will terminate your rights to receive the worker's compensation benefits specified above on the date indicated. This form is not a release of the employer's or the insurance carrier's workers' compensation liability. It is merely a receipt of compensation paid. The claimant has the right within five years after the date of the last payment to petition the Office of Workers' Compensation for additional benefits.

Document No. 60-07-01-02-12/97

Exhibit 5

PHYSICIAN'S FORM
INSTRUCTIONS/DEFINITIONS

The use of this form is required by the Delaware Workers' Compensation Statute, 19 Del.C. §2322E, to report all information specific to this workers' compensation injury. In the event the physician electronically generates this information, the physician's submission is required to contain all information specific to this workers' compensation injury as set forth in the Physician's Form.

Complete all applicable fields. Your office notes and records do not replace this form.

1. **Report Type:** Check "Initial" if this is the first visit related to this described injury. Check "Progress" when there has been any material change in the injured employee's physical capability which impacts the employee's return to work status. Check "Closing" if: injured worker is discharged from care.

2. **Case Information:**
   - **Injured Worker's Name:** Name of the injured worker.
   - **Date of Birth:** The injured worker's date of birth.
   - **Date of Injury:** Date of this injury.
   - **Exam Date:** Date of office visit if applicable.
   - **Physician's Phone/Fax:** The telephone and fax numbers of the physician completing this form.
   - **Employer Name:** The name of the employer associated with the claim.
   - **Employer Phone/Fax:** The telephone and fax numbers of the employer.
   - **Insurer Name:** The name of the insurance carrier associated with the claim, if known.
   - **Insurer Claim #:** The claim number assigned by the insurance carrier or self-insured employer, if known.
   - **Insurer Phone/Fax:** The telephone and fax numbers of the insurance carrier associated with the claim, if known.

3. **Initial Visit:** Relate in injured worker's words description of accident/injury.

4. **Work Related Medical Diagnosis(es):** State the injured worker's work related medical diagnosis(es).

5. **Treatment Plan:** Complete all applicable portions regarding treatment. Indicate frequency and duration.
   - **Diagnostic tools/tests:** EMG, MRI, CT-scan, etc.
   - **Procedures:** Any medical procedure including surgical procedures, castings, etc.
   - **Therapy:** Physical therapy, occupational therapy, home exercise, etc., including plan specifications.
   - **Medications:** Antibiotics, analgesics, anti-inflammatory drugs, etc.
   - **Other:** Any treatment not covered above.

6. **Hours Per Day Patient Can Work:** Circle the number of hours applicable to this patient.

7. **D.O.T. Classification of Work:** Circle the classification of work applicable to this patient.

8. **Work Postures/Positional Tolerances:** Comment as appropriate in the space provided regarding the patient's abilities/limitations for the postures/positions listed.

9. **Comments:** To be used to explain/clarify any information required by this form.

10. **Restrictions:** Check applicable category.

11. **Return to Work:** Provide regular duty/modified duty start date.

12. **Reevaluation Date:** Provide date of next evaluation.

13. **Physician Information:** Type or print the name of the physician and circle "yes" or "no" as to whether the physician is a Certified Provider. The health care provider most responsible for the treatment of the employee's work-related injury must sign and date the report.

The health care provider most responsible for the treatment of the employee's work-related injury shall complete and submit, as expeditiously as possible and not later than 10 days after the date of first evaluation or treatment, a report of employee condition and limitations, on a form adopted for that purpose pursuant to this section, and shall expeditiously provide copies of the report of employee condition and limitations to the employee, the employer and the employer's insurance carrier, if applicable, as required by 19 Del. C. §2322E(b).

DELAWARE WORKERS' COMPENSATION
PHYSICIAN'S REPORT OF WORKER'S COMPENSATION INJURY
A COPY OF THIS REPORT MUST BE SENT TO THE INJURED WORKER, EMPLOYER AND THE INSURER

REPORT TYPE ___ Initial ___Progress ___Closing

WORKER'S NAME_____

DOB _____
Date of Injury _____
EXAM DATE _____
Physician's Phone/Fax_____

Employer Name _____
Employer Phone/Fax _____
Insurer Name _____
Insurer Claim No. _____
Insurer Phone/Fax _____

INITIAL VISIT ONLY
Injured worker's description of accident/injury_____

_____

WORK RELATED MEDICAL DIAGNOSIS (ES) _____

_____

TREATMENT PLAN:
Diagnostic Tests_____
Procedures_____
Therapy_____
Medications_____

Hrs. per day patient can work: (circle one) 8 6 4 2 0

D.O.T. Classification of Work (Circle one)

Sedentary Exerting up to 10 lbs. of force *occasionally* and/or a negligible amount of force *frequently* to lift, carry, push, pull or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time.

Light Exerting up to 20 lbs. of force *occasionally* and/or up to 10 lbs. of force *frequently* and/or negligible amount of force *constantly* to move objects. Physical demand requirements are in excess of those for Sedentary Work.

Medium Exerting 20 to 50 lbs. of force *occasionally* and/or 10 to 25 lbs. of force *frequently* and or greater than negligible up to 10 lbs. of force *constantly* to move objects. Physical Demand requirements are in excess of those for Light Work.

Heavy Exerting 50 to 100 lbs. of force *occasionally* and/or 25 to 50 lbs. of force *frequently* and/or 10 to 20 lbs. of force *constantly* to move objects. Physical Demand requirements are in excess of those for Medium Work.

Very Heavy Exerting in excess of 100 lbs. of force *occasionally* and/or in excess of 50 lbs. of force *frequently* and/or in excess of 20 lbs. of force *constantly* to move objects. Physical Demand requirements are in excess of those for Heavy Work.

Definitions:
Occasionally: activity or condition exists up to 1/3 of the time
Frequently: activity or condition exists from 1/3 to 2/3 of the time
Constantly: activity or condition exists 2/3 or more of the time

Work Postures/Positional tolerances: Comment **as appropriate** in the space provided regarding the patient's abilities/limitations for the following

Postures/Positions. (e.g. Sitting: No more than 30 minutes continuously)

Sitting: _____ Squatting: _____
Standing: _____ Crawling: _____
Walking: _____ Climbing: _____
Driving: _____ Repeated arm motions: _____
Bending: _____ Repetitive use of wrist/hands: _____
Turn/Twist: _____ Reaching up above shoulder: _____
Kneeling: _____ Foot controls: _____

Comments:_____

_____

_____

Above safe work capacities are: temporary _____ permanent _____ anticipate full duty release _____

Return to work modified duty start date: _____

RELEASE TO FULL DUTY WITH NO RESTRICTIONS (Please Circle) YES (Start date_____) NO

Physician Signature: _____ Date: _____

Physician Name: (Please print)_____ Certified Provider:: YES NO

Exhibit 6

EMPLOYER'S FORM INSTRUCTIONS/DEFINITIONS
The use of this form is required by the Delaware Workers' Compensation Statute, 19 Del.C. §2322E, to report all information specific to this workers' compensation injury.

Complete all applicable fields.

1. **Case Information:**
   Employer Name: The name of the employer associated with the claim.
   Employee Name: Name of the injured worker.
   Modification Duty Information: Complete all applicable fields
   Employer Fax: The telephone and fax numbers of the employer.
   Job Title: Provide job title for position available.
   Job Description: Provide description of physical requirements of job duties for position available.
   Environment/Working Conditions: Identify any environmental factors relevant to position available.

2. **Hours Per Day Job Available**: Circle the number of hours applicable.

3. **Additional Information**: Circle the applicable work status categories for the position available, and comment as appropriate in the space provided regarding the work postures/positional requirements for the modified duty job available.

4. **Employer**: Provide job availability date.

5. **Comments**: To be used to explain/clarify any information required by this form.

6. **Employer Information**: The person responsible for completing this form on behalf of the employer must sign and date this form.

WITHIN 14 DAYS OF THE ISSUANCE OF AN "AGREEMENT AS TO COMPENSATION" PAYABLE TO AN EMPLOYEE FOR ANY PERIOD OF TOTAL DISABILITY, THE EMPLOYER SHALL PROVIDE THIS FORM TO THE HEALTH CARE PROVIDER/PHYSICIAN MOST RESPONSIBLE FOR THE TREATMENT OF THE EMPLOYEE'S WORK-RELATED INJURY, AND TO THE EMPLOYER'S INSURANCE CARRIER, IF APPLICABLE. THE INSURANCE CARRIER FOR AN INSURED EMPLOYER SHALL SEND TO SUCH EMPLOYER THE AFOREMENTIONED REPORT FOR COMPLETION, AND SHALL BE INDEPENDENTLY RESPONSIBLE FOR PROVIDING A COMPLETED REPORT OF MODIFIED DUTY JOBS TO THE HEALTH CARE PROVIDER/PHYSICIAN, AS REQUIRED BY 19 *Del. C.* §2322E(d).

IF THE "PHYSICIAN'S REPORT OF WORKERS' COMPENSATION INJURY" RELEASES THE EMPLOYEE TO FULL DUTY, DO NOT COMPLETE THIS FORM.

THE HEALTH CARE PROVIDER/PHYSICIAN MUST COMPLETE HIS/HER PORTION OF THIS FORM AND SIGN AND RETURN IT TO THE EMPLOYER WITHIN FOURTEEN (14) DAYS OF THE NEXT DATE OF SERVICE AFTER THE PHYSICIAN'S RECEIPT OF THE FORM FROM THE EMPLOYER, BUT NOT LATER THAN TWENTY-ONE (21) DAYS FROM THE PHYSICIAN'S RECEIPT OF SUCH FORM.

DELAWARE WORKERS' COMPENSATION
EMPLOYER'S MODIFIED DUTY AVAILABILITY REPORT

CARRIER/TPA WC #: _____ DATE: _____

EMPLOYER: _____ FAX#: _____

EMPLOYEE: _____ IS MODIFIED DUTY AVAILABLE: ____ Yes ____ No

IF AVAILABLE, FOR WHAT PERIOD OF TIME: _____ Weeks _____ Indefinite

JOB TITLE: _____ JOB DESCRIPTION: _____

ENVIRONMENT/WORKING CONDITIONS (e.g., Temperature): _____

Hrs. per day job available: (circle minimum and maximum) 8 6 4 2 0

D.O.T. Classification of Work (Circle one)

Sedentary	Exerting up to 10 lbs. of force occasionally and/or a negligible amount of force frequently to lift, carry, push, pull or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time.
Light	Exerting up to 20 lbs. of force occasionally and/or up to 10 lbs. of force frequently and/or negligible amount of force constantly to move objects. Physical demand requirements are in excess of those for Sedentary Work.
Medium	Exerting 20 to 50 lbs. of force occasionally and/or 10 to 25 lbs. of force frequently and or greater than negligible up to 10 lbs. of force constantly to move objects. Physical Demand requirements are in excess of those for Light Work.
Heavy	Exerting 50 to 100 lbs. of force occasionally and/or 25 to 50 lbs. of force frequently and/or 10 to 20 lbs. of force constantly to move objects. Physical Demand requirements are in excess of those for Medium Work.
Very Heavy	Exerting in excess of 100 lbs. of force occasionally and/or in excess of 50 lbs. of force frequently and/or in excess of 20 lbs. of force constantly to move objects. Physical Demand requirements are in excess of those for Heavy Work.

Definitions:

Occasionally: activity or condition exists up to 1/3 of the time
Frequently: activity or condition exists from 1/3 to 2/3 of the time
Constantly: activity or condition exists 2/3 or more of the time

Work Postures/Positional requirements: Comment **as appropriate** in the space provided regarding the following Postures/Positions for the modified duty job available.

Sitting: _____ Squatting: _____ Standing:
Crawling: _____ Walking: _____ Climbing: _____

Driving: _____ Repeated arm motions: _____ Bending:
Turn/Twist: _____ Kneeling: _____ Foot controls: _____

Reaching up above shoulder: _____ Repetitive use of wrist/hands: _____

Comments: _____

EMPLOYER: _____

Date job is available: _____

Comments: _____

Employer Signature: _____ Date: ____

PHYSICIAN: I approve the job described above. ( )Yes. ( ) No.

If no, reasons for disapproval/recommended modifications: _____

_____

Physician Signature: _____ Date: _____

Physician Name (Please print) _____ Certified provider: YES NO (Circle)

The Health Care Provider/Physician MUST complete his/her portion of this form and SIGN and RETURN it to the EMPLOYER within fourteen (14) days of the next date of service after the HC Provider/Physician's receipt of the form from the employer, but not later than twenty-one (21) days from the HC Provider/Physician's receipt of such form.

Exhibit 7

APPENDIX A
DELAWARE DEPARTMENT OF LABOR
MEDICAL UTILIZATION REVIEW PROGRAM
REQUEST FOR UTILIZATION REVIEW
(Pursuant to **19 Del.C. §2322F(j)**)
PLEASE TYPE OR CLEARLY PRINT ALL INFORMATION.
All information and addresses must be verified as current and accurate.

1. Date of Request_____
2. WC Number(s)_____ Date(s) of injury_____
3. Nature of Injury/Practice Guideline(s)_____
4. Claimant's Name_____ Age_____ Sex_____
Address_____ Tel. No._____
City_____ State_____ Zip_____
5. Employer_____
6. Party Requesting Review _____
Primary Contact at Party's Office_____
Email Address_____
Address_____ Tel. No._____
City_____ State_____ Zip_____
7. Name of Claimant's Attorney_____
Address_____
8. Health Care Providers to be Reviewed and other Health Care Providers Impacted by this Review:
(a) Health Care Provider to be Reviewed_____
Specialty (if applicable)_____
Date of first treatment _____
Address_____ Tel. No._____
City_____ State_____ Zip_____
(b) Health Care Provider to be Reviewed_____
Specialty (if applicable)_____
Date of first treatment _____
Address _____Tel. No. _____
City_____ State_____ Zip_____
(c) Additional Health Care Providers to be reviewed (list name, specialty, address, etc. on a separate sheet)
(d) Health Care Facility(s) Impacted (e.g. hospital, ambulatory surgery center, etc.) by this retrospective review (list name, address, etc. on a separate sheet)
9. Treatment to be reviewed: Specify the health care service to be reviewed and the timeframe within which the treatment was or will be rendered.

_____
_____
_____

My signature certifies the following: (a) all names and addresses on this form have been verified as current and accurate; (b) two identical copies of associated medical material are being submitted for review; (c) the bill denial for the treatment subject to this review was sent within 30 days of receiving the provider's bill; and (d) all items listed in the table of contents are in each copy of the medical material.

_____ _____
Print Name of Requester Signature of Requester

COPY THIS FORM OR REPRODUCE EXACTLY IN APPEARANCE AND CONTENT. SEE INSTRUCTIONS ON BACKREQUIRED CONTENT, PRESENTATION AND BINDING METHOD
FOR ALL MATERIALS SUBMITTED FOR UTILIZATION REVIEW

In accordance with **19 Del.C. §2322 F(j)** and the regulations adopted pursuant thereto, all information and medical records submitted to the Department of Labor, Office of Workers' Compensation must represent all of the facts of this case.

INFORMATION PACKAGE · REQUIRED CONTENT

- Completed and signed Request for Utilization Review Form.
- If applicable, a list containing 1) names, addresses, etc. of the health care facilities impacted by this review; and 2) additional health care providers under review.
- Proof of date of issuance of claim denial (so the Department of Labor is able to verify that Utilization Review was requested within 15 days of the date of the claim denial).

MEDICAL RECORDS PACKAGE· REQUIRED CONTENT

Section 1. All reports, notes, etc., from provider being reviewed from the date of injury or the two (2) year period immediately preceding the treatment to be reviewed, whichever is shorter, and the time frame within which the treatment to be reviewed was or will be rendered, as submitted to the requesting party.

Section 2. All reports, notes, etc., of other treating providers from the date of injury or the one (1) year period immediately preceding the treatment to be reviewed, whichever is shorter, as submitted to the requesting party.

Section 3. All diagnostic test results from the date of injury or the two (2) year period immediately preceding the treatment to be reviewed, whichever is shorter, as submitted to the requesting party.

NOTE Do not include copies of any billing statements or comments/instructions directed to the Utilization Review panel. All material **must** be presented in identified sections; each section's content must be presented in chronological order.

REQUIRED PRESENTATION AND BINDING METHOD FOR ALL SUBMITTED MATERIALS

a. All submitted material must be presented in two (2) identical bound copies.
b. If tabs are used for the sections, they must be positioned to the right side of the document.

Mail or Deliver to: **Department of Labor**
Office of Workers' Compensation
Medical Component Division
4425 N. Market St.
Wilmington, DE 19802

Exhibit 8

Delaware Workers' Compensation Health Care Payment System

JUSTIFICATION FOR USE OF NON-PREFERRED MEDICATION

A pharmacist **must** dispense a non-preferred/brand name drug or medication upon the physician's or other authorized individual's completion of this "Justification For Use Of Non-Preferred Medication" form.

Patient/Injured Worker: _____

Practitioner Name: _____

Office Contact: _____ Phone Number: _____ Fax Number: _____

Have you checked the Prescription Monitoring Program (PMP) profile for this patient? Yes No

Current or previous Preferred medication(s): _____

_____

_____

Selected Non-Preferred medication(s): _____

_____

_____

Was symptom(s) controlled on prior regimen? Yes No

Additional comments: _____

_____

_____

_____

Pursuant to 19 **Del. C.** §2322F(g):

> "(g) If, following a hearing, the Industrial Accident Board determines that an employer, an insurance carrier or a health care provider failed in its responsibilities under § 2322B, § 2322C, § 2322D, § 2322E or § 2322F of this title, it shall assess a fine of not less than $1,000 nor more than $5,000 for violations of said sections. Such fines shall be payable to the Workers' Compensation Fund."

Distribution of this form:
The prescriber gives this form to the injured worker, along with the prescription. The injured worker gives this form to the pharmacist.

I hereby certify that I have reviewed and complied with the Pharmacy Regulations regarding Preferred and Non-Preferred drugs and medications as set forth in the Pharmacy Regulations, 19 **DE Admin Code** 1341, Section 4.13 and hereby authorize the dispensing of the above drug(s) and/or medication(s).

Signature of physician
or other authorized individual: _____ **Date:** _____

Exhibit 9

PETITION FOR COMMUTATION

TO THE INDUSTRIAL ACCIDENT BOARD OF THE STATE OF DELAWARE

SITTING IN AND FOR_____ COUNTY

_____ Claimant	_____ SS#	_____ Carrier File #
vs.	_____ Carrier/Self-Insurer Name	
_____ Employer	_____ Date of Injury	_____ Case File No.

The undersigned prays that your Honorable Board shall, after due notice of the time and place of hearing served on all parties in interest, hear and determine the matter in accordance with the facts and the law, and state its conclusions of fact and rulings of law.

Petition for Commutation of Benefits, Pursuant to §2358:
(Please check the appropriate blocks(s))

_____ Total Disability, Pursuant to §2324

☐ Partial Disability, Pursuant to §2325

☐ Permanent Impairment, Pursuant to §2326

☐ All Benefits, Except Medical Expenses

☐ 2nd Injury Fund, Pursuant to §2327

☐ All Benefits, Including Medical Expenses

☐ Medical Expenses Only

☐ Other _____

_____

Petition for Commutation of Benefits, Pursuant to §2358:

☐ The parties agree to the above settlement commutation to be presented by stipulation to the board.

The person who the parties agreed with is _____

_____

☐ The parties contest the above commutation and request a pre-trial hearing.

Dated this _____day of _____A.D. 20 _____.

_____
Name

_____
Address

_____

Exhibit 10

STATE OF DELAWARE
DEPARTMENT OF LABOR
DIVISION OF INDUSTRIAL AFFAIRS
4425 NORTH MARKET STREET
WILMINGTON, DELAWARE 19801

PHONE: (302) 761-8200
FAX: (302) 736-9170

REQUEST FOR COPY OF PUBLIC DOCUMENT

NAME OF REQUESTOR:_____DATE:_____

BUSINESS OF REQUESTOR: _____

ADDRESS: _____

_____

TELEPHONE NUMBER:_____

DOCUMENT DESCRIPTION

(Example) Copy of any and all file materials pertaining to any worker's compensation claim involving the claimant:

CLAIMANT'S NAME: _____

INDUSTRIAL ACCIDENT BOARD (CASE FILE) NUMBER:_____

SOCIAL SECURITY NUMBER:_____

DATE OF ACCIDENT:_____

SIGNATURE OF REQUESTOR: _____

FOR DEPARTMENT OF LABOR USE ONLY

NUMBER OF PAGES COPIED _____ @ 0.25 PER PAGE = $_____

MAILING COSTS: $_____ **TOTAL AMOUNT DUE $_____**

PICK UP ____

MAIL _____

PAID BY: CHECK _____ CASH _____

Exhibit 11

PETITION TO DETERMINE COMPENSATION DUE TO INJURED EMPLOYEE

To the Industrial Accident Board of the State of Delaware

Sitting in and for _____ County

Claimant SS# _____

_____
Claimant

Date of Birth _____

vs.

Insurance Carrier _____

_____
Employer

Case File No. _____

The undersigned petitioner respectfully represents:

That the above named claimant and the above named employer have failed to reach an agreement in regard to compensation due said claimant as an employee of said employer.

The undersigned therefore prays that your Honorable Board shall, after due notice of the time and place of hearing served on all parties in interest, hear and determine the matter in accordance with the facts and the law and state its conclusions of fact and rulings of law.

My signature on this petition is authorization for any doctor, hospital, other health care provider, or State of Delaware Division of Vocational Rehabilitation to supply any and all medical records and reports to the bearer of the original or a copy of this petition regarding any medical condition provided all requests for this information are in writing.

Dated this _____day of _____A.D. 20____

_____
Claimant's Signature

Name of Attorney, if applicable _____

INDUSTRIAL ACCIDENT BOARD
STATE OF DELAWARE

Statement of Facts Upon Failure to Reach an Agreement

1. Name of Employee _____

   Address _____

   City_____ State_____ Zip _____

   Telephone Number _____E-mail (optional) _____

2. Date of Accident _____ 3. Place of Accident _____

4. Name of Employer _____

   Employer Contact Name_____ E-mail (optional) _____

   Address _____

   City_____ State _____ Zip _____

   Telephone Number _____Fax # _____

5. Name of Insurance Carrier / 3rd Party Administrator _____

6. Occupation of employee at the time of accident _____

7. Describe accident/illness and how it happened _____

_____

_____

_____

8. List the body part(s)/illness _____

_____

_____

9. Did employee receive medical, surgical or hospital service? ◯Yes ◯No

10. When was notice of injury given to or received by employer? _____

11. Give names and addresses of all employers for the last 5 years. If more space is needed, attach a separate sheet.

NAME:	**ADDRESS:**

12. State weekly wage when injured _____

13. State names and addresses of all treating doctors for this claim. If more space is needed, attach a separate sheet.

NAME:	**ADDRESS:**

14. State names and address of all other treating doctors for the last 10 years. If more space is needed, attach a separate sheet.

NAME:	**ADDRESS:**

15. Give names and addresses and dates of treatment of all hospitals and institutes treating you for this injury. If more space is needed, attach a separate sheet.

NAME:	**ADDRESS:**

16. To what extent did injury prevent employee from working and for how long _____

_____

17. State whether or not employee has fully recovered and if only partially to what extent _____

_____

18. If employee has resumed work, state

a) when and give name of present employer _____

_____

b) what trade or occupation and weekly wages _____

_____

19. Identify, give description and dates of all previous and subsequent injuries.

_____

_____

20. State any other important facts bearing on the case above presented _____

_____

_____

_____

PETITION TO DETERMINE COMPENSATION DUE TO DEPENDENTS OF DECEASED EMPLOYEE

_____

To the Industrial Accident Board of the State of Delaware

Sitting in and for _____ County

_____
Claimant (Deceased Employee)

vs.

_____
Employer

}

Claimant SS# _____

Date of Birth _____

Insurance Carrier _____

Case File No. _____

The undersigned petitioner respectfully represents:

That the above named claimant and the above named employer have failed to reach an agreement in regards to compensation due said claimant as the dependent of _____ _____a deceased employee of said employer.

The undersigned therefore prays that your Honorable Board shall, after due notice of the time and place of hearing served on all parties in interest, hear and determine the matter in accordance with the facts and the law and state its conclusions of fact and rulings of law.

Dated this _____day of _____A.D. 20 ___.

Witness:

_____
Signature

_____
Print Name

Name:

_____
Signature

_____
Print Name

Document Control #: B60-07-12-12-11

INDUSTRIAL ACCIDENT BOARD
STATE OF DELAWARE

Statement of Facts Upon Failure to Reach an Agreement

1. Name of Employee _____

   Address _____

   City_____ State_____ Zip_____

   Telephone Number _____E-mail (optional) _____

2. Date of Accident _____ 3. Place of Accident _____

4. Name of Employer _____

   Employer Contact Name_____ E-mail (optional)_____

   Address _____

   City_____ State _____ Zip _____

   Telephone Number _____Fax #_____

5. Name of Insurance Carrier / 3rd Party Administrator_____

6. Occupation of employee at the time of accident _____

7. Nature of accident and how it happened _____

_____

8. Describe the nature of injury _____

_____

_____

9. Did employee receive medical, surgical or hospital service? ☐ Yes ☐ No

10. When was notice of injury given to or received by employer?_____

11. Give names and addresses of all employers for the last 5 years. If more space is needed, attach a separate sheet.

NAME:	**ADDRESS:**

12. State weekly wage when injured _____

13. State names and addresses of all treating doctors for this claim. If more space is needed, attach a separate sheet.

NAME:	**ADDRESS:**

14. State number of weeks employed during the last twelve months _____

15. State at what trade or occupation employed during the last twelve months _____

_____

16. Date of death _____

17. What were the expenses of last sickness and burial _____

_____

18. Amount of these expenses paid by the employer _____

_____

19. Name of widow or widower of deceased, if dependent _____

_____

20. Names and dates of birth of dependent children under sixteen years of age.

_____ _____

_____ _____

_____ _____

_____ _____

21. Names and addresses of surviving father and mother of deceased, if dependent.

_____ _____

22. Give names and dates of birth of dependent sibling(s) of deceased under sixteen years of age.

_____ _____

_____ _____

23. State any other important facts bearing on the case above presented.

_____

_____

_____

PETITION TO DETERMINE ADDITIONAL COMPENSATION DUE TO INJURED EMPLOYEE

To the Industrial Accident Board of the State of Delaware sitting in and for

_____ County.

_____	)	_____	_____
Claimant	)	SS#	Carrier File #
vs.	)	_____	
	)	Carrier / Self-Insurer Name	
_____	)	_____	_____
Employer	)	Date of Injury	Case File No.

The undersigned prays that your Honorable Board shall, after due notice of the time and place of hearing served on all partied in interest, hear and determine the matter in accordance with the facts and the law, and state its conclusions of fact and rulings of law.

Petition for additional compensation due – Please check the appropriate block(s):

☐ Recurrence of the total disability benefits, pursuant to §2324 for the period(s) _____

_____

☐ Recurrence of partial disability benefits, pursuant to §2325 for the period(s) _____

_____

☐ Permanent impairment, pursuant to §2326.

Permanency Percentage:				
Part of Body:				
Dr. who rated permanency:				

☐ Transportation expenses

☐ Medical expenses/bills, <u>other than appeals for a utilization review determination</u>. Use the DACD petition dedicated for utilization review determination appeals for those medical expenses.

☐ Other _____

My signature on this Petition is authorization for any doctor, hospital, other health care provider, or State of Delaware Division of Vocational Rehabilitation to supply any and all medical records and reports to the bearer of the original or a copy of this petition regarding any medical condition provided all requests for this information are in writing.

Dated this _____day of _____ A.D. 20 _____.

_____
Claimant's Signature

_____
Address

_____
City, State, and Zip Code

_____
Phone Number

PETITION TO DETERMINE DISFIGUREMENT

_____

To The Industrial Accident Board of the State of Delaware Sitting in and for _____ County

_____Petitioner)
)
vs.) Case File No. _____
_____)
)
_____ Employer)

The undersigned petitioner respectfully represents:

Being desirous of having a hearing on the ground that _____has sustained a disfigurement to the following part/parts of the body _____ resulting from a compensable industrial accident which occurred on_____ and became permanent as of _____, the undersigned respectfully prays that your Honorable Board shall, after due notice of the time and place of hearing served on all parties in interest, hear and determine the matter in accordance with the facts and the law, and state its conclusion of fact and rulings of law.

Dated this _____day of _____A.D. 20_____

_____
Name

_____
Address

_____

PETITION FOR REVIEW

To the Industrial Accident Board of the State of Delaware sitting in and for

_____ County.

_____)	_____	_____	_____	
Employer)	SS #	Carrier File #	OWC Case File #	
)				
vs.)	_____ Carrier/Self-Insurer Name		_____ Name of Adjuster	
_____)	_____	_____	_____	
Claimant.	Date of Injury	Adjuster's Phone #	Adjuster's E-mail, If Applicable	

The undersigned prays that your Honorable Board shall, after due notice of the time and place of hearing served on all parties in interest, hear and determine the matter in accordance with the facts and the law, and state its conclusions of fact and rulings of law.

Petition for Termination of Benefits, Pursuant to §2347:

☐ Claimant returned to work

☐ Claimant is physically able to return to work

☐ Failure to sign agreement(s) / receipt(s)

☐ Missed employer medical examination (s), pursuant to §2343 (b)

☐ Failure to comply with Board's order for vocational rehabilitation services

☐ Claimant's partial disability has terminated or diminished

☐ Other:

Petition to Order Vocational Rehabilitation, Pursuant to §2353 (a):

☐ To obtain an order requesting the claimant's cooperation with vocational rehabilitation services

Petition for Workers' Compensation Fund, Pursuant to §2327:

☐ Reimbursement from the Workers' Compensation Fund

Dated the _____ day of _____ A.D. 20_____.

_____
Name of Attorney

_____
Address

_____

Document Control #: F60-07-12-12-11

PETITION FOR COMMUTATION

TO THE INDUSTRIAL ACCIDENT BOARD OF THE STATE OF DELAWARE

SITTING IN AND FOR _____ COUNTY

_____ Claimant	_____ SS#	_____ Carrier File #
vs.	_____ Carrier/Self-Insurer Name	
_____ Employer	_____ Date of Injury	_____ Case File No.

The undersigned prays that your Honorable Board shall, after due notice of the time and place of hearing served on all parties in interest, hear and determine the matter in accordance with the facts and the law, and state its conclusions of fact and rulings of law.

Petition for Commutation of Benefits, Pursuant to §2358:
(Please check the appropriate blocks(s))

_____ Total Disability, Pursuant to §2324

☐ Partial Disability, Pursuant to §2325

☐ Permanent Impairment, Pursuant to §2326

☐ All Benefits, Except Medical Expenses

☐ 2nd Injury Fund, Pursuant to §2327

☐ All Benefits, Including Medical Expenses

☐ Medical Expenses Only

☐ Other _____

_____

Petition for Commutation of Benefits, Pursuant to §2358:

☐ The parties agree to the above settlement commutation to be presented by stipulation to the board.

The person who the parties agreed with is _____

_____

☐ The parties contest the above commutation and request a pre-trial hearing.

Dated this _____day of _____A.D. 20 _____.

_____
Name

_____
Address

_____

Document Control #: E60-07-12-12-11

PETITION TO DETERMINE ADDITIONAL COMPENSATION DUE TO INJURED EMPLOYEE
- APPEAL A UTILIZATION REVIEW (UR) DETERMINATION

To the Industrial Accident Board of the State of Delaware sitting in and for

_____ County.

_____	)	_____	_____
Claimant,	)	SS#	Carrier File #
	)		
vs.	)	_____	
	)	Carrier / Self-Insurer Name	
_____	)	_____	_____
Employer.	)	Date of Injury	Case File No.

The undersigned prays that your Honorable Board shall, after due notice of the time and place of hearing served on all partied in interest, hear and determine the matter in accordance with the facts and the law, and state its conclusions of fact and rulings of law.

This petition is a *de novo* review of a UR determination, pursuant to Title 19 **Del.C.** §2322F(j) and 19 **DE Admin Code** 1341. Please provide the information below:

1. Date petitioner received the UR Determination via certified mail (appeal must be filed within 45 days from date of UR determination receipt). _____

2. Date (s), Practice Guideline(s), and Treatment(s) involved in the Utilization Review.

Date(s):	Practice Guideline(s):	Treatment(s):
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____

3. Name and Address of the Health Care Provider(s) whose treatment was questioned in this UR.

Dated this _____ day of _____ A.D. 20 _____ .

_____
Name of Petitioning Party

_____
Address

_____
City, State, and Zip Code

_____
Phone Number

Exhibit 12

AGREEMENT BY EXECUTIVE OFFICER(S)/LLC MEMBERS(S) NOT TO BE SUBJECT TO THE DELAWARE WORKERS' COMPENSATION LAW

Executive officers of corporations and members of Limited Liability Companies (LLCs) are covered under the Delaware Workers' Compensation Law. However, up to eight (8) executive officers who are stockholders of a corporation or up to four (4) members of an LLC may elect not to be subject to Delaware Workers' Compensation Law by completing this agreement with their corporation/LLC. ***SPECIAL NOTE:*** - ***CONSTRUCTION*** corporations/ LLCs subject to Title 30, Chapter 25 of the Delaware Code may elect to exclude up to four (4) executive officers who are stockholders of a corporation or up to four (4) members of an LLC. Executive Officers are the president, any vice president, secretary, treasurer or any other executive officer(s) elected by the board of directors in accordance with the charter and the regularly adopted by-laws of the corporation . This Executive Officer/LLC member Exclusion Procedure must be repeated each time a corporation/LLC wishes to change the status of any executive officer/LLC member and/or secures coverage from a different carrier group.

Name of business

_____

Federal Employer Identification Number ☐☐☐☐☐☐☐☐☐

Business ***has*** employee(s) (other than those listed below) - please check here ____
Business ***does not have*** employee(s) (other than those listed below) - please check here____

Please check type of business

□ **Corporation** Not Subject to Title 30, Chapter 25 (non construction) – *Maximum 8 exclusions*
□ **Corporation** Subject to Title 30, Chapter 25 (**construction**) – *Maximum 4 exclusions*
□ **Limited Liability Company** (LLC) – *Maximum 4 exclusions*

_____ _____ _____
Signature of Representative of Corporation or LLC ***Title*** ***Date***

Named below are the executive officer(s)/LLC member(s) electing not to be subject to the Delaware Workers Compensation Law:

NAME(s) (Print name)	TITLE	MEMBER OFFICER(S) SIGNATURE	STOCKHOLDER YES/NO	DATE

Additional space below limited to officers of corporations not subject to Title 30, Chapter 25. Cannot be used for other corporations or any LLC.

IMPORTANT: If you have workers compensation insurance, you *must* submit the *original* of this completed form to your insurance carrier, together (in the case of a corporation) with the shareholders resolution(s), shareholders agreement(s), and/or shareholders written consent(s) evidencing the executive officer status of the electing executive officer(s), or together (in the case of an LLC) with the operating agreement and/or certificate of formation evidencing the member status of the electing member(s). If you are a subcontractor, you *must* also provide a copy of the same documents to each general contractor by whom you are hired.

FRANKLIN & PROKOPIK
A PROFESSIONAL CORPORATION
ATTORNEYS AT LAW

The B & O Building
2 N. Charles Street, Suite 600
Baltimore, Maryland 21201
410.752.8700
410.752.6868 Fax

111 North West Street
Suite 200
Easton, Maryland 21601
410.820.0600
410.820.0300 Fax

1101 Opal Court
Hub Plaza, Suite 210
Hagerstown, Maryland 21740
301.745.3900
301.766.4676 Fax

2325 Dulles Corner Boulevard
Suite 1150
Herndon, Virginia 20171
703.793.1800
703.793.0298 Fax

800 Creek View Road
Suite 300
Newark, Delaware 19711
302.594.9780
302.594.9785 Fax

5516 Falmouth Street
Suite 203
Richmond, Virginia 23230
804.932.1996
804.403.6007 Fax