



**WORKERS' COMPENSATION COMMISSION**

**GUIDE FORM to be made a part of  
PROPOSED FINAL COMPROMISE & SETTLEMENT AGREEMENT**

Claim Number:

Claimant:

Employer:

Insurer:

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WHEREAS the undersigned, Claimant or Claimant's attorney avers as follows:

YES NO

- 1. Is the claim Currently contested as to compensability and/or causation? -----
- 2. Is further medical treatment for the injury recommended? -----  
If yes, does the Claimant have health care coverage for the recommended treatment? -----
- 3. Is there any potential S.I.F. liability in this case? -----
- 4. Is the Claimant working? -----
- 5. Is a third party claim involved in this case? -----  
- If yes, attach required document per Rule .19B.
- 6. Is this claim on appeal? -----
- 7. Is there a hearing pending on this claim? -----  
If YES, When? -----
- 8. Are the proceeds of this settlement to be payable weekly OR in a lump sum?
- 9. All pertinent medical reports are attached OR There are no medicals in this case.
- 10. Comments:

\_\_\_\_\_  
Signature of Claimant

\_\_\_\_\_  
Signature of Claimant's Attorney

**Attach only relevant  
medical information.**

Address:  
Suite, etc.:  
City, State, Zip Code:  
Telephone Number:

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410-864-5100 • Email: info@wcc.state.md.us • Web: http://www.wcc.state.md.us