

WORKERS' COMPENSATION COMMISSION
10 EAST BALTIMORE STREET
BALTIMORE, MD 21202-1641

SOLE PROPRIETOR'S STATUS AS A COVERED EMPLOYEE FORM

I hereby represent to the Maryland Workers' Compensation Commission, that I am a sole proprietor doing business in and about the State of Maryland, and that on the date set forth below my signature, and under the penalty of perjury, the following checked box represents my status as a covered employee.

I have elected to become a covered employee under Section 9-227 of the Labor and Employment Article, and have submitted the requisite Inclusion form (C15R) with the Workers' Compensation Commission.

I have not elected to become a covered employee under Section §9-227 of the Labor and Employment Article.

Name of Sole Proprietor: _____

Address: _____

Social Security Number or FEIN Number: _____

I AFFIRM UNDER THE PENALTY OF PERJURY THAT THE FOREGOING INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF.

Signature

Date

Note: No investigation or hearing was conducted by the Workers' Compensation Commission to verify this representation, but as it was made under the penalty of perjury, it is accepted as being true and correct on the date set forth above. This representation is not binding on the Workers' Compensation Commission under any circumstance.

Sole Proprietor Status (9/30/02)

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