BWC
Better Workers' Compensation
Built with *you* in mind

Governor Bob Taft
Administrator/CEO James Conrad

# First Report of an Injury, Occupational Disease or Death

**WARNING:**
Any person who obtains compensation from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false statements or accepting compensation to which he or she is not entitled, is subject to felony criminal prosecution for fraud.
(R.C. 2913.48)

Tear off this sheet and return the completed form to your employer's managed care organization (MCO) or to your local BWC customer service office.

## Injured worker and injury/disease/death info.

| Last name, first name, middle initial | | | Social Security number | Marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed | Date of birth |
|---|---|---|---|---|---|
| Home mailing address | | | Sex ☐ Male ☐ Female | | Number of dependents |
| City | State | 9-digit ZIP | Country if different from USA | | Department name |
| Wage $ _____ Per: ☐ Hour ☐ Year ☐ Month ☐ Other ☐ Week | | | What days of the week do you usually work? ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat | | Regular work hours From _____ To _____ |
| Have you been offered or do you expect to receive payment or wages for this claim from anyone other than the Ohio Bureau of Workers' Compensation? ☐ Yes ☐ No If yes, please explain. | | | | | Occupation or job title |

Employer name

Mailing address (number and street, city or town, state, ZIP code and county)

Location, if different from mailing address

Was the place of accident or exposure on employer's premises? ☐ Yes ☐ No
(If no, give accident location, street address, city, state and ZIP code)

| Date of injury/disease | Time of injury _____ ☐ a.m. ☐ p.m. | If fatal, give date of death | Time employee began work _____ ☐ a.m. ☐ p.m. | Date last worked | Date returned to work |
|---|---|---|---|---|---|
| Date hired | State where hired | | Date employer notified | | |

| Description of accident (Describe the sequence of events that directly injured the employee, or caused the disease or death.) | Type of injury/disease and part(s) of body affected (For example: sprain of lower left back) |
|---|---|
| | |
| | |
| | |

***Benefit application/medical release*** *– I am applying for recognition of my claim under the Ohio Workers' Compensation Act for work-related injuries that I did not purposely inflict. I request payment for compensation and/or medical expenses as allowable. Direct payment(s) to the providers of any medical services are authorized. I understand that I am allowing any provider who attends to, treats or examines me to release all medical, psychological and/or psychiatric information that is causally or historically related to physical or mental injuries relevant to issues necessary to the administration of my workers' compensation claim to the Ohio Bureau of Workers' Compensation, the Industrial Commission of Ohio, the employer listed in this claim, that employer's managed care organization and any authorized representatives. I further authorize the Ohio Rehabilitation Services Commission to release information about my physical, mental, vocational and social conditions that is causally or historically related to physical or mental injuries relevant to issues necessary for the administration of my workers' compensation claim to the aforementioned parties.*

| Injured worker signature | Date | E-mail address | Telephone number ( ) | Work number ( ) |
|---|---|---|---|---|
| | | | | |

## Treatment info.

| Health-care provider name | Telephone number ( ) | Fax number ( ) | Initial treatment date |
|---|---|---|---|
| Street address | City | State | 9-digit ZIP code |

Diagnosis(es): Include ICD code(s)

| Will the incident cause the injured worker to miss eight or more days of work? ☐ Yes ☐ No | Is the injury causally related to the industrial incident? ☐ Yes ☐ No | |
|---|---|---|
| Health-care provider signature | 11-digit BWC provider number | Date |

## Employer info.

| Employer policy number | Check if ☐ Employer is self-insuring ☐ Injured worker is owner/partner/member of firm | | | |
|---|---|---|---|---|
| Telephone number ( ) | Fax number ( ) | E-mail address | Federal ID number | Manual number |

| Was employee treated in an emergency room? ☐ Yes ☐ No | Was employee hospitalized overnight as an inpatient? ☐ Yes ☐ No |
|---|---|

If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code

☐ **Certification -** The employer certifies that the facts in this application are correct and valid.

☐ **Rejection -** The employer rejects the validity of this claim for the reason(s) listed below:

**For self-insuring employers only**

☐ **Clarification -** The employer clarifies and allows the claim for the condition(s) below:
☐ **Medical only** ☐ **Lost time**

| Employer signature and title | Date | OSHA case number |
|---|---|---|
| | | |