



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)

Governor Bob Taft
Administrator/CEO James Conrad

Injured worker and injury/disease/death info.	Last Name, First Name, Middle Initial			Social Security Number		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Date of Birth	
	Home Mailing Address			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female				Number of Dependents	
	City		State	9-digit ZIP		County if different from USA		Department Name	
	Wage \$ ____ Per. <input type="checkbox"/> Hour <input type="checkbox"/> Month <input type="checkbox"/> Week <input type="checkbox"/> Year <input type="checkbox"/> Other ____			What days of the week do you usually work? <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thur <input type="checkbox"/> Fri <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO							Occupation of 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 premise? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, give accident location, street address, city, state and ZIP code)								
	Date of injury/disease		Time of injury <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		If fatal, give date of death		Time employee began work <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		Date last worked
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)			
<p><i>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 health 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 mental injuries relevant to issues necessary for the administration of my workers' compensation claim to the aforementioned parties.</i></p>									
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-9 Code(s)								
	<p>Will the incident cause the injured worker to miss eight or more days of work? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the injury causally related to the industrial incident? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>								
	Health-care provider signature				11-digit BWC provider number			Date	

Employment	Employer policy number			Check if	<input type="checkbox"/> Employer is self-insuring				
	Telephone number		Fax number		E-mail address		Federal ID number		Manual number
	Was employee treated in an emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No				Was employee hospitalized overnight as an inpatient? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code								
	<input type="checkbox"/> Certification – The employer certifies that the facts in this application are correct and valid.			<input type="checkbox"/> Rejection – The employer rejects the validity of this claim for the reason(s) listed below:			For self-insuring employers only <input type="checkbox"/> Clarification – The employer clarifies and allows the claim for the condition(s) below <input type="checkbox"/> Medical Only <input type="checkbox"/> Lost time		
Employer Signature and Title						Date		OSHA Case Number	