



First Report of an Injury, Occupational Disease or Death

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.

- By signing this form, I:
• Elect to only receive compensation and/or benefits that are provided for in this claim under Ohio workers' compensation laws;
• Waive and release my right to receive compensation and benefits under the workers' compensation laws of another state for the injury or occupational disease, or death resulting from an injury or occupational disease, for which I am filing this claim;
• Agree that I have not and will not file a claim in another state for the injury or occupational disease or death resulting from an injury or occupational disease for which I am filing this claim;
• Confirm that I have not received compensation and/or benefits under the workers' compensation laws of another state for this claim, and that I will notify BWC immediately upon receiving any compensation or benefits from any source for this claim.

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)

Injured worker and injury/disease/death info. Last name, first name, middle initial; Social Security number; Marital status; Date of birth; Home mailing address; Sex; Number of dependents; City; State; 9-digit ZIP code; Country if different from USA; Department name; Wage rate; What days of the week do you usually work?; Regular work hours; 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?; Occupation or job title; Employer name; Mailing address; Location; Was the place of accident or exposure on employer's premises?; Date of injury/disease; Time of injury; If fatal, give date of death; Time employee began work; Date last worked; Date returned to work; Date hired; State where hired; Date employer notified; Description of accident; Type of injury/disease and part(s) of body affected.

Benefit application/medical release - I am applying for a claim under the Ohio Workers' Compensation Act for work-related injuries that I did not purposely inflict. I affirm that I elect to receive compensation and benefits under the Ohio workers' compensation laws for my claim, and I waive and release my right to file for and receive compensation and benefits under the laws of any other state for this claim. I request payment for compensation and/or medical benefits as allowable, and authorize direct payment to my medical providers. I permit and authorize any provider who attends, treats or examines me, and the Ohio Rehabilitation Services Commission (where relevant) to release medical, psychological, psychiatric, vocational or social information that is causally or historically related to my physical or mental injuries relevant to issues necessary for the administration of my claim to: BWC, the Industrial Commission of Ohio, the employer in this claim, the employer's BWC MCO and any authorized representatives.

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); Will the incident cause the injured worker to miss eight or more days of work?; Is the injury causally related to the industrial incident?; Health-care provider signature; 11-digit BWC provider number; Date

Employer info. Employer policy number; Telephone number; Fax number; E-mail address; Federal ID number; Manual number; Was employee treated in an emergency room?; Was employee hospitalized overnight as an inpatient?; 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.; 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

