

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



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/she is not entitled, is subject to felony criminal prosecution for fraud.

(R.C. 2913.48)

For faster service

Complete as much of all four sections of this form as possible. Type or print in black or blue ink.

Injured Worker Info.	Last Name, First Name, Middle Initial			Social Security Number	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <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 Code	Country if different than U.S.A.	Department Name	
	Wage Rate \$ _____ 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 for this claim from anyone other than the Ohio Bureau of Workers' Compensation or the employer? <input type="checkbox"/> YES <input type="checkbox"/> NO				Occupation or Job Title	
	Benefit Application/Medical Release <i>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 related to 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>					
				Telephone Number	Work Number	
				Injured Worker Signature		Date

Injury/Disease/Death Info.	Date of Injury/Disease	Time of Injury _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	If fatal, give date of death	Date Last Worked	Date Returned to Work	
	Accident Location (street address)		Date Hired	State Where Hired	Date Employer Notified	
	City		State	Was place of accident or exposure on employer's premises? <input type="checkbox"/> YES <input type="checkbox"/> NO		
	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, etc.)		

Treatment Info.	Physician/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)			Will this incident cause the injured worker to miss eight or more days of work? <input type="checkbox"/> YES <input type="checkbox"/> NO	
				Is this injury causally related to the industrial incident? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	Provider Signature		BWC Provider Number	Date	

Employer Info.	Employer Name		Policy Number	<input type="checkbox"/> Employer is Self-Insuring <input type="checkbox"/> Injured Worker is Owner/Partner/Member of Firm		
	Mailing Address (Number and Street, City or Town, State, and ZIP Code)				County	
	Location, if different from mailing address				Manual Number	
	Telephone Number () () ()	Fax Number () () ()	Federal ID number			
	<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 following reason(s) below:		FOR SELF-INSURING EMPLOYERS ONLY <input type="checkbox"/> CLARIFICATION - The employer clarifies and allows the claim for the condition(s) below	
Employer Signature and Title			Date	OSHA Case Number		