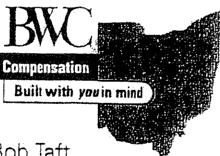

Governor Bob Taft
Administrator/CEO James Conrad

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 30600051

Check if ☐ Employer is self-insuring ☐ Injured worker is owner/partner/member of firm

Telephone number (419) 738-3422 | Fax number (419) 738-1267 | E-mail address | Federal ID number 34-1845819 | 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 Superintendent | Date | OSHA case number

BWC-1101 (Rev. 9/2003)

FROI-1 (Combines C-1, C-2, C-3, C-6, C-50, OD-1, OD-1-22)

This form meets OSHA 301 requirements

RETURN TO WORK FORM

PHYSICIAN: Please complete the date of re-evaluation and specify all initial functional restrictions/abilities so that Auglaize County Educational Service Center may make all reasonable efforts to accommodate work restrictions by providing safe alternative productive work whenever possible.
Please FAX completed form to (419) 738-1267 Transitional Work Coordinator.

Name of Worker: ______________________ Date of Birth: __________ Claim #:______________

TO BE COMPLETED BY PHYSICIAN

I most recently evaluated this employee on (date) ______________________ and certify that:

☐ Worker is able to return to full and unrestricted work activities as of (date) ____________.

☐ Worker may participate in a Transitional Work Program and is medically stable to perform work activities that are compatible with his/her restrictions. Medical status will be re-evaluated on (date) ______________. This worker should be initially assigned to daily work activities that will not exceed the following restrictions/abilities:

STAND / WALK	SITTING	RIGHT ARM USE	LEFT ARM USE
☐ UNLIMITED	☐ UNLIMITED	☐ UNLIMITED	☐ UNLIMITED
☐ 7-8 HOURS	☐ 7-8 HOURS	☐ 7-8 HOURS	☐ 7-8 HOURS
☐ 5-6 HOURS	☐ 5-6 HOURS	☐ 5-6 HOURS	☐ 5-6 HOURS
☐ 3-4 HOURS	☐ 3-4 HOURS	☐ 3-4 HOURS	☐ 3-4 HOURS
☐ 1-2 HOURS	☐ 1-2 HOURS	☐ 1-2 HOURS	☐ 1-2 HOURS
☐ NONE	☐ NONE	☐ NONE	☐ NONE

OCCASIONAL LIFTING	FREQUENT LIFTING	OPERATION OF FOOT CONTROLS	OTHER RESTRICTIONS/ FUNCTIONAL ABILITIES
☐ UNLIMITED	☐ UNLIMITED	☐ UNLIMITED	☐ ____________
☐ 41-60 LB.	☐ 21-30 LB.	☐ 7-8 HOURS	☐ ____________
☐ 21-40 LB.	☐ 11-20 LB.	☐ 5-6 HOURS	☐ ____________
☐ 11-20 LB.	☐ 6-10 LB.	☐ 3-4 HOURS	☐ ____________
☐ 1-10 LB.	☐ 1-5 LB.	☐ 1-2 HOURS	☐ ____________
☐ NONE	☐ NONE	☐ NONE	☐ ____________

☐ Worker has reached maximum medical recovery and may participate in an objective functional capacities evaluation of permanent restrictions to ensure safe job placement.

☐ Worker is medically unstable and unable to perform any work activities (even on a part-time basis) at this time. Medical status will be re-evaluated on (date) ______________.

______________________ ______________________ ______________________
Physician's Signature Print Name Date

Developed by Advanced Transitions, Inc. (2004)

PERRP Form 301P

INJURY and ILLNESS INCIDENT REPORT

1) Employee Full Name: ______________________________

2) Street: ______________________________

City/State/Zip: ______________________________

3) Date of birth: ____/____/____ 4) Date hired: ____/____/____

5) ☐ Male ☐ Female

11) Date of injury or illness ____/____/____

12) Time employee began work day of case: __________ AM / PM

13) Time of event: __________ AM / PM

14) **What was employee doing just before the incident occurred?** (Describe the activity. Be specific.)

15) **What happened?** (State how injury occurred.)

16) **What was the injury or illness?** (State part(s) of body that was affected and how it was affected; be more specific than "hurt", "pain", or "sore". Example: "strained back".)

17) **What object or substance directly harmed the employee?**

10) Case number from OSHA log (completed by office personnel): __________

Complete only if consult Health Care Professional regarding this case:

6) Name of physician or other health care professional ______________________________

7) If treatment was given away from the worksite, where was it given?

Facility: ______________________________

Street: ______________________________

City/State/Zip: ______________________________

8) Was employee treated in an emergency room? ______ Yes ______ No

9) Was employee hospitalized overnight as an in-patient? ______ Yes ______ No

18) If the employee died, when did death occur? Date of death ____/____/____

Information completed by: ______________________________ Title: ______________________________

Phone: ______________________________ Date: ______________________________

This form is required by Public Law 91-596 and 29 CFR 1904 and must be kept in the establishment for 5 years following the year to which it pertains.

U.S. Department of Labor, Occupational Safety and Health Administration