Bureau of Workers' Compensation

First Report of an Injury, Occupational Disease or Death

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 ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed | Date of birth

Home mailing address | Sex ☐ Male ☐ Female | Number of dependents

City | State | 9-digit ZIP code | Country if different from USA | Department name

Wage rate $ ____________ Per: ☐ Hour ☐ Month ☐ Week ☐ Year ☐ Other ________

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 | State where supervised

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 release of information – I am applying for a claim under the Ohio Bureau of Workers' Compensation Act for work-related injuries that I did not inflict. I affirm that I elect to receive compensation and benefits under Ohio's 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, the Ohio State Board of Pharmacy, the Ohio Department of Job and Family Services and the Ohio Rehabilitation Services Commission to release medical, psychological, psychiatric, pharmaceutical, vocational and social information. I understand this may include personally identifying information that is casually 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 managed care organization and any authorized representatives. My previous or future BWC claims may affect decisions made in this claim. Proper administration of the present claim may require BWC to share claims information with the employers of record (or their authorized representatives) and/or my authorized representative for any and all such previous or future claims. The released claims information may include any record maintained in my claim files.

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

E code | 11-digit BWC provider number | Date

Health-care provider signature

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

Bureau of Workers' Compensation

Physician's Report of Work Ability

Injured worker name	Claim number	Date of injury
Employer name and injured worker's position of employment at time of injury	Date of last exam or treatment	Next appointment date

Injured worker progress

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The injured worker is progressing: ☐ As expected ☐ Better than expected ☐ Slower than expected

If a MEDCO-14 was previously completed for this injured worker, are there any changes to the information provided in Section 2 through 7 to report at this time? ☐ Yes ☐ No *If yes, proceed to section 2. If no, proceed to section 8.*

Work status

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Did you review a description of the injured worker's job duties as they existed on the date of injury (former position of employment)? Check all applicable boxes.

☐ Yes, I was provided a job description (verbal or written) by the ☐ Injured worker ☐ Employer ☐ MCO

☐ No, I have not been provided a job description.

Select one of the three options below.

☐ Injured worker is temporarily not released to any work, including the former position of employment from (date): ____/_____/_____ to ____/_____/_____. *Please complete required sections 4, 5, 6, 7 and 8.*

☐ Injured worker is not released to the former position of employment but may return to available and appropriate work with restrictions, from (date): ____/_____/_____ to ____/_____/_____. *Please complete required sections 3, 4, 5, 6, 7 and 8.*

The restrictions are: ☐ Permanent ☐ Temporary If temporary until what date? ____/_____/_____

☐ Injured worker is released to the former position of employment without restrictions as of (date): ____/_____/_____.

Is this date the day the injured worker actually returned to work? ☐ Yes ☐ No ☐ I don't know: *Proceed to section 8 and complete it.*

Injured worker's capabilities: Employer will use information in this section to evaluate available and appropriate work opportunities

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How many total hours is this injured worker potentially able to work? _____________ Hours in a day _____________ Hours in a week

Upper extremities

The injured worker is able to perform simple grasping with: ☐ Left hand ☐ Right hand ☐ Both

The injured worker is able to perform repetitive wrist motion with: ☐ Left hand ☐ Right hand ☐ Both

The injured worker's dominant hand is: ☐ Left ☐ Right

Lower extremities

The injured worker is able to perform repetitive actions to operate foot controls or motor vehicles with: ☐ Left foot ☐ Right foot ☐ Both

Medications

The injured worker is able to safely perform work duties which, if applicable, may include operating heavy machinery or driving while taking prescribed medications: ☐ Yes ☐ No

If no, what are the potential side effects: ☐ Dizziness ☐ Drowsiness ☐ Impaired ability ☐ Other, please explain

Please indicate the following: N = Never, O = Occasionally, F = Frequently, C = Continuously

Lifting/carrying	N	O	F	C	Pushing/pulling	N	O	F	C	Activity	N	O	F	C	Activity	N	O	F	C
0 – 10 lbs.					13 to 25 lbs.					Bend					Reach above shoulder				
11 – 20 lbs.					26 to 40 lbs.					Squat					Type/keyboard				
21 – 40 lbs.					41 to 60 lbs.					Kneel					**Driving**				
41 – 60 lbs.					61 to 100 lbs.					Twist/turn					Automatic				
61 – 100 lbs.					100 + lbs.					Climb					Standard shift				

In an eight-hour workday, how many total hours is the injured worker potentially able to work?

Sit: ___ hours ☐ Continuously ☐ With break | **Walk:** ___ hours ☐ Continuously ☐ With break | **Stand:** ___ hours ☐ Continuously ☐ With break

Degree of functional impairment based on allowed psychological conditions only, if applicable.

	None	Mild	Moderate	Marked	Extreme
Activities of daily living: Self-care, personal hygiene, communication, ambulation, travel, sexual function, sleep, social and recreational activities and occupational functioning	☐	☐	☐	☐	☐
Social functioning: Capacity to interact and communicate effectively and get along with others	☐	☐	☐	☐	☐
Concentration, persistence and pace: Ability to sustain focused attention long enough to complete tasks commonly found in the workplace	☐	☐	☐	☐	☐
Adaptation: Ability to appropriately react to stressful circumstances, including the workplace; includes attendance, making decisions, scheduling or completing tasks and interacting with supervisors and co-workers	☐	☐	☐	☐	☐

Injured worker name	Claim number	Date of injury

Disability period information (all fields required, including site/location if applicable)

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Complete the chart below and furnish the narrative description of the diagnosis(es), site/location, if applicable, and ICD code for the conditions being treated due to the work-related injury. Please indicate if the condition is causing temporary total disability **(all fields required, including site/location, if applicable).**

Narrative description of the work-related condition	Site/Location If applicable	ICD code	Is the condition causing temporary total disability?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

List all other conditions being treated (attach additional sheet if necessary).

Clinical findings

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Provide your clinical and objective findings supporting your medical opinion outlined on this form. List any barriers to return to work and any reason for the injured worker's delay in recovery.

Maximum medical improvement (MMI)

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MMI is a treatment plateau (static or well-stabilized) at which no fundamental functional or physiological change can be expected within reasonable medical probability in spite of continuing medical or rehabilitative procedures. An injured worker may need supportive treatment to maintain this level of function. Note: periodic medical treatment may still be requested and provided.

Has the work-related injury(s) or occupational disease reached MMI based on the definition above? ☐ Yes ☐ No

If yes, give MMI date: ______/______/______. If no, please provide the proposed treatment plan, including estimated duration of each treatment (attach additional sheet if necessary).

Vocational rehabilitation

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Vocational rehabilitation is an individualized and voluntary program for an eligible injured worker who needs assistance in safely returning to work or in retaining employment. This program can be tailored around an injured worker's restrictions, and may provide job seeking skills or necessary retraining. Is the injured worker a candidate for vocational rehabilitation services focusing on return to work?

☐ Yes ☐ No If no, please explain why and provide your recommendations to help the injured worker return to employment.

Treating physician signature - mandatory

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I certify the above information is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain payment as provided by BWC or who knowingly accepts payment to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Treating physician's name (please print legibly)			Physician PEACH number	
Address	City	State	Nine-digit ZIP code	Telephone number – –
Treating physician signature			Date	Fax number – –

KEY CONTACT INFORMATION

MEDICAL MANAGEMENT INFORMATION

FAX Medical Information:
- 800-334-4229

MAIL Medical Information:
- CHS
  PO Box 1040
  Dublin, OH 43017

Prior Authorization:
- Fax C-9 form to 800-334-4229

MEDICAL BILL PAYMENT INFORMATION

MAIL Medical Bills:
- CHS
  PO Box 1040
  Dublin, OH 43017

Billing Questions:
- Call CHS Customer Service toll-free 888-247-7799

OTHER IMPORTANT INFORMATION

Prescriptions:
- For questions regarding prescriptions, contact SXC Health Solutions, toll-free at 800-OHIOBWC, press zero (0), select option three (3)

Provider Search:
- Visit www.chsmco.com for provider searches

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PO Box 1040, Dublin, OH 43017 | 7731 E. Kemper Road, Cincinnati, OH 45249
5700 Lombardo Center Drive, Ste 150, Seven Hills, OH 44131 | 3130 Executive Pkwy, Ste 2F, Toledo, OH 43606
888-247-7799 | WWW.CHSMCO.COM

STEPS TO TAKE
WHEN A WORKPLACE INJURY OCCURS

INJURED EMPLOYEE

1. Immediately report the injury to your supervisor
2. Complete the BWC First Report of Injury form
3. Seek medical treatment
4. Take your ID card to all appointments
5. Let your supervisor know that you have received medical treatment for your work-related injury

EMPLOYER

1. Complete the Employment section of the BWC First Report of Injury form
2. Fax the completed form to CHS toll-free at 800-334-4229
3. Stay in touch with the injured worker while they are off work

IN EMERGENCY CASES, INJURED WORKERS SHOULD IMMEDIATELY NOTIFY THEIR EMPLOYER AND SEEK TREATMENT AT THE NEAREST MEDICAL FACILITY. *According to Health Partnership Program (HPP) guidelines, injured workers may seek treatment from any BWC-certified medical provider.

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