

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)

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 from USA		Department name		
Wage rate \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Month <input type="checkbox"/> Week			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 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 place of accident or exposure on employer's premises? <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"/> AM <input type="checkbox"/> PM		If fatal, give date of death		Time employee began work _____ <input type="checkbox"/> AM <input type="checkbox"/> PM		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, etc.)			
<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 related causally or historically 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 related causally and historically to physical or mental injuries relevant to issues necessary for the administration of my workers' compensation claim to the aforementioned parties.</i></p>									
Injured worker signature				Date		Telephone number ( ) ( )		Work number ( ) ( )	

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)								
<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	

Employer policy number			<b>CHECK IF</b> <input type="checkbox"/> Employer is self-insuring <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO				Was employee hospitalized overnight as an in-patient? <input type="checkbox"/> YES <input type="checkbox"/> NO				
If treatment was given away from worksite, provide the facility name, street address, city, state, ZIP code								
<input type="checkbox"/> <b>CERTIFICATION</b> - The employer certifies that the facts in this application are correct and valid.			<input type="checkbox"/> <b>REJECTION</b> - The employer rejects the validity of this claim for the following reason(s) below:			<b>FOR SELF-INSURING EMPLOYERS ONLY</b> <input type="checkbox"/> <b>CLARIFICATION</b> - The employer clarifies and allows the claim for the condition(s) below:		
Employer signature and title						Date		OSHA case number