



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?
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?
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
State where supervised
Description of accident
Type of injury/disease and part(s) of body affected

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?
Is the injury causally related to the industrial incident?
Health-care provider signature
11-digit BWC provider number
Date

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?
Was employee hospitalized overnight as an inpatient?
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

