



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.

Form section for injured worker and injury/disease/death info, including fields for 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, wage rate, regular work hours, occupation or job title, employer name, mailing address, location, date of injury/disease, time of injury, date last worked, date returned to work, date hired, state where hired, date employer notified, state where supervised, description of accident, and type of injury/disease.

Treatment info.

Form section for treatment info, including fields for health-care provider name, telephone number, fax number, initial treatment date, street address, city, state, 9-digit ZIP code, diagnosis(es), 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, and date.

Employer info.

Form section for employer info, including fields for employer policy number, 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?, certification/rejection/clarification options, employer signature and title, date, and OSHA case number.

