

For faster service

Complete as much of this form as possible.

Type or print in black or blue ink.

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, subject to felony criminal prosecution for fraud.

Tear off this sheet and return completed form to your local BWC Customer Service Office (see front of this application for addresses)

Injured Worker	Last Name, First Name, Middle Initial			Telephone Number	Social Security Number	Date of Birth
	Home Address			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced	Number of Dependents
	City	State	9-digit ZIP Code	County	<input type="checkbox"/> Married <input type="checkbox"/> Separated	Department Name
	Wage Rate \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Month <input type="checkbox"/> Week <input type="checkbox"/> Year <input type="checkbox"/> Other _____			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 for this claim from anyone other than the Ohio Bureau of Workers' Compensation or the employer? <input type="checkbox"/> YES <input type="checkbox"/> NO					
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 that attends to, treats or examines me to release all medical, psychological, and/or psychiatric information that is related to my workers' compensation claim to the Ohio Bureau of Workers' Compensation, the Ohio Industrial Commission and my employer listed in this claim.		Occupation or Job Title	
					Injured Worker Signature	Date

Injury/Disease/Death	Date of Injury/Disease	Time of Injury _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	If fatal, give date of death	Date Last Worked	Date Returned to Work
	Was place of accident or exposure on employer's premises? <input type="checkbox"/> YES <input type="checkbox"/> NO		Date Hired	State Where Hired	Date Employer Notified
	Accident Location (street address)			City	State
	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.)	

Treatment	Physician/Health-Care Provider Name	Telephone Number ()	Date of Initial Treatment	BWC Provider Number
	Street Address	City	State	9-digit ZIP Code
	Diagnosis(es): Include ICD-9 Code(s)			
	Provider Signature	This diagnosis is causally related to this industrial accident. <input type="checkbox"/> YES <input type="checkbox"/> NO		

Employment	Employer Name	Risk Number	<input type="checkbox"/> Employer is Self-Insuring <input type="checkbox"/> Injured Worker is Owner/Partner/Member of Firm		
	Mailing Address (Number and Street, City or Town, State, and ZIP Code)			County	
	Location, if different from mailing address			Manual Number	
	<input type="checkbox"/> CERTIFICATION - The employer certifies that the facts in this application are correct and valid.		<input type="checkbox"/> REJECTION - The employer rejects the validity of this claim for the following reason(s):		FOR SELF-INSURING EMPLOYERS ONLY: <input type="checkbox"/> CLARIFICATION - The employer clarifies and allows the claim for the condition(s) below:
	Employer Signature and Title			Date	Telephone Number ()