

# 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 to 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.

**CompManagement**  
Health Systems, Inc.

888-247-7799 [www.chsmco.com](http://www.chsmco.com)



# 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)

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.

Injured worker and injury/disease/death info.

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 <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 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 the 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"/> a.m. <input type="checkbox"/> p.m.		If fatal, give date of death		Time employee began work _____ <input type="checkbox"/> a.m. <input type="checkbox"/> 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)			
<p><b>Benefit application release of information</b> - 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 the Ohio 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, and the Ohio Rehabilitation Services Commission (where relevant) to release medical, psychological, psychiatric, vocational or social 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 BWC 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.</p>									
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? <input type="checkbox"/> Yes <input type="checkbox"/> No						Is the injury causally related to the industrial incident? <input type="checkbox"/> Yes <input type="checkbox"/> No		
E code				11-digit BWC provider number		Date		
Health-care provider signature								

Employer info.

Employer policy number			<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 inpatient? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If treatment was given away from work site, provide the facility name, street address, city, state and 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 reason(s) listed 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: <input type="checkbox"/> <b>Medical only</b> <input type="checkbox"/> <b>Lost time</b>	
Employer signature and title					Date		OSHA case number





- Instructions**
- Physician must complete this form when the injured worker is under work restrictions or is temporarily totally disabled.
  - You must send or fax a copy of the completed form to the managed care organization (MCO) and a copy given to the injured worker at time of exam.
  - You may use any other physician-generated document provided that the substitute document contains, at a minimum, the data elements on the MEDCO-14.
  - If injured worker is employed by a self-insuring employer complete this form and mail or fax it to the self-insuring employer.
  - List ICD-9 codes for the allowed conditions being treated that prevent return to work.

**Fax Note:**

To	From
Toll-free phone number	Phone number
Toll-free fax number	Fax number

Injured worker name	Claim number	SSN if claim number unknown	Date of injury / /
Injured worker occupation		Employer name	

<b>WORK ACTIVITY</b>	<input type="checkbox"/> May return to work (RTW) with no restrictions on _____	<b>Work/Non-Work Capabilities</b>				
	<input type="checkbox"/> May RTW with restrictions due to work-related injury/disease from _____ to _____ (complete work/non-work capabilities on the right). Work restrictions apply to work and non-work activity. If restrictions cannot be met at work, then injured worker is recommended to be off work.	<b>% of Workday (8 hr)</b>	<b>None at all</b>	<b>Occasional</b>	<b>Frequent</b>	<b>Continuous</b>
	The restrictions are <input type="checkbox"/> permanent <input type="checkbox"/> temporary? If temporary, how long? _____	<b>0%</b>	<b>1-33%</b>	<b>34-66%</b>	<b>67-100%</b>	
	<input type="checkbox"/> Is totally disabled from work from _____ to _____. Please explain in the space provided below why the injured worker is unable to work, due to work-related injury/disease. List ICD-9 codes for the allowed conditions being treated which prevent return to work. _____	<b>Repetitions per hr</b>	<b>4-6</b>	<b>6-12</b>	<b>&gt;12</b>	
Estimated RTW date _____	Lift/Carry					
	Up to 10 lbs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	11-20 lbs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	21-50 lbs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	51-100 lbs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Bending.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Twist/turn.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Reach below knee.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Push/pull.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Squat/kneel.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Stand/walk.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Sit.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	No lifting above shoulders..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<b>Hand restrictions</b> <input type="checkbox"/> Left <input type="checkbox"/> Right	<b>No use of</b> <input type="checkbox"/> Left <input type="checkbox"/> Right				
	<input type="checkbox"/> Must wear splint	<input type="checkbox"/> Arm				
	<input type="checkbox"/> No lifting greater than _____ lbs	<input type="checkbox"/> Hand				
	<input type="checkbox"/> No repetitive activities	<input type="checkbox"/> Finger _____				
	<input type="checkbox"/> No work with hot or cold substances	<input type="checkbox"/> Other _____				
	<input type="checkbox"/> Change positions every _____	<input type="checkbox"/> Work activity as splint/bandage permits				
	<input type="checkbox"/> Avoid driving	<input type="checkbox"/> Keep wound clean/dry				
	<input type="checkbox"/> _____	<input type="checkbox"/> Limit working to _____ Hrs./Day				

Physician's further explanation of work abilities or why the injured worker is unable to perform any work: \_\_\_\_\_

**MMI** Has the work-related injury(s) or occupational disease reached a treatment plateau at which no fundamental functional or physiological change can be expected despite continuing medical or rehabilitative intervention (maximum medical improvement):  Yes  No

▶ **Note: Periodic medical treatment may still be requested and provided.**

IF YES, give date \_\_\_\_\_ IF NO, please explain (attach additional sheet if necessary)

**REHAB**  Check if vocational rehabilitation return to work services are indicated.

Physician name and address (please print, type or stamp)

Date of this exam / /	Follow-up appointment Date / /	Time
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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, imprisonment, or both.

Physician signature (mandatory) \_\_\_\_\_ Date / /

**EMPLOYEE INCIDENT AND INJURY REPORT**  
**To be completed by employee**  
**PLEASE PRINT IN INK**



Injured worker's name \_\_\_\_\_ Location \_\_\_\_\_

Employer Name \_\_\_\_\_

Social security number \_\_\_\_\_ Gender:  Male  Female

Home address \_\_\_\_\_ Birth Date \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Home telephone no. (\_\_\_\_) \_\_\_\_\_

Date of injury or onset of symptoms \_\_\_\_\_ Time \_\_\_\_\_  am  pm

Where did the accident occur: \_\_\_\_\_

Described what caused the injury/symptoms, what you were doing **just before** the incident, and what you did **after** the incident (if you need more space, use additional paper). **Be specific - name any objects or substances involved:** \_\_\_\_\_

Did anyone see you get hurt?  Yes  No If yes, who? \_\_\_\_\_

Did you report this incident to anyone?  Yes  No If not, why not? \_\_\_\_\_

If yes, to whom did you report it? \_\_\_\_\_ Title/Position \_\_\_\_\_

When? Date: \_\_\_\_\_ Time: \_\_\_\_\_

What part(s) of your body was/were affected? (BE SPECIFIC: for example, right elbow, left knee, right index finger):  
\_\_\_\_\_

What type of injury did you experience? (BE SPECIFIC: for example, bruise, scrape, pull, laceration)  
\_\_\_\_\_

Was any first aid provided at the scene?  Yes  No If yes, describe: \_\_\_\_\_

Did you seek other medical treatment?  Yes  No If yes, when? \_\_\_\_\_

Name of Physician, Hospital or Urgent Care \_\_\_\_\_

If treatment was not sought immediately, explain why:  
\_\_\_\_\_  
\_\_\_\_\_

Is this an aggravation of a previous injury/symptom?  Yes  No If yes, when were you last treated for the previous injury?

By whom or where? \_\_\_\_\_

Have you ever had a similar injury?  Yes  No If yes, describe other injury: \_\_\_\_\_

**Medical Release**

***Under current workers' compensation provisions, the employer is entitled to a signed medical release***

I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to **disclose such information** to my employer, my employer's managed care organization, **CompManagement, Health Systems, Inc** or to my employer's designated representative. A copy of this form will serve as the original.

Employee Name (print) \_\_\_\_\_

Employee Signature \_\_\_\_\_

Date (required) \_\_\_\_\_

Injured Worker's Signature: \_\_\_\_\_

**INVESTIGATION**

**To be completed by Department Manager**

**PLEASE PRINT IN INK**

CIRCLE Y or N

**Cause of Accident**

- Y N Protective equipment not used (gloves, safety glasses, proper shoes etc.)
  - Y N Using improper tools or devices
  - Y N Unsafe position or posture ( Lifting with bent back, unnecessary exposure to chemicals re; chlorine)
  - Y N Horseplay
  - Y N Failure to secure equipment
  - Y N Failure to obtain assistance (moving heavy loads without assistance)
  - Y N Failure to remove slipping or tripping hazards
  - Y N Unsafe procedures not classified above:
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**Contributing Cause**

- Y N Lack of knowledge or skill
- Y N Performance contrary to instructions
- Y N Known hazards not corrected
- Y N Safety rules not enforced
- Y N Physically not qualified for the job
- Y N Questionable being under the influence of drugs or alcohol

**Contributing Condition**

- Y N Unsafe building conditions (broken stair treads, uneven floors, loose or missing handrails etc)
  - Y N Hidden defects in equipment or material (sharp edges, worn, frayed etc.)
  - Y N Hazardous arrangement (improperly stored or piled materials, blocked aisles, overloaded shelving)
  - Y N Improper lighting
  - Y N Improper ventilation
  - Y N Natural elements (wind, snow, ice etc.)
  - Y N Unsafe mechanical or physical condition not listed above:
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**Action to Prevent Accident Recurrence**

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Has the injured worker returned to work            Y            N            Date returned \_\_\_\_\_

Date prepared \_\_\_\_/\_\_\_\_/\_\_\_\_

Prepared by \_\_\_\_\_

Title \_\_\_\_\_

Manager's Signature \_\_\_\_\_