In an emergency, immediately notify your employer and seek treatment at the nearest medical facility. A BWC-certified healthcare provider must provide medical services after the initial treatment. Call MinuteMen OhioComp if you need help locating a BWC-certified medical provider.

Injury reporting made easy!

Injured employee steps:

1. Immediately notify your employer of the injury.
2. Seek medical treatment from the nearest medical facility. A BWC-certified health-care provider must provide medical services after the initial treatment.
3. Show the MinuteMen OhioComp card to all medical providers treating your injury.
4. Complete the *BWC First Report of Injury* (FROI) form and any accident report that may be required by your employer.

Employer steps:

1. Complete the employer portion of BWC's *First Report of Injury* (FROI) form.
2. Fax the completed form to MinuteMen OhioComp at 1-888-644-7339.
3. Report the injury by phone to MinuteMen OhioComp at 1-888-644-6266 or 216-426-0646.

MINUTEMEN OHIOCOMP MANAGED CARE ORGANIZATION

INJURED WORKER IDENTIFICATION CARD

Please present to your medical provider when seeking initial medical treatment.

MINUTEMEN OHIOCOMP MANAGED CARE ORGANIZATION

WORKERS' COMPENSATION IDENTIFICATION CARD

Employer Name: STOW MUNROE FALLS CITY SCHOOLS

Employer Risk/Policy No: 37751851000

First Report of Injury • Case Management Billing Questions 1-888-644-6266

Injured at work?

WHAT TO DO IF YOU ARE INJURED ON THE JOB

- **In case of medical emergency seek immediate treatment at the nearest medical facility.**
- Notify your Supervisor immediately and assist in filing a First Report of Injury report.
- Obtain your Stow-Munroe Falls City Schools injury packet from your supervisor.
- When seeking treatment, please let the medical provider know that MinuteMen OhioComp is your MCO and present your MinuteMen OhioComp card.

ALERT!

- With the exception of emergency medical care, you must receive treatment from a BWC certified medical provider or your medical treatment may not be covered.

STOW-MUNROE FALLS CITY SCHOOLS

Contact your supervisor with any questions

MINUTEMEN OHIOCOMP MANAGED CARE ORGANIZATION

For information about medical treatment contact:
MinuteMen OhioComp
Managed Care Organization
1-888-644-6266
www.minutemenmco.com

STOW-MUNROE FALLS CITY SCHOOLS PREFERRED PROVIDERS

Western Reserve Occupational Health	3913 Darrow Rd., Ste 100 Stow, Ohio 44224	**(330) 928-9675**	Monday - Friday 7 am - 5 pm Saturday - Sunday 8 am - 4 pm
Summa Center for Corporate Care	1860 State Rd., Ste. C Cuyahoga Falls, Ohio 44223	**(330) 940-5770**	Monday - Friday 7:30 am - 4:30 pm
For severe injuries and after hours			
Western Reserve Hospital Emergency Room	1900 23rd St. Cuyahoga Falls, Ohio 44223	**(330) 971-7000**	24 hours, daily

Ohio | Bureau of Workers' Compensation

First Report of Injury, Occupational Disease, or Death (FROI)

Submit the form to BWC in one of the following ways. **Online:** www.bwc.ohio.gov, **Fax:** 1-866-336-8352, **Mail:** BWC Mail Processing Center, Attn: Claims, 30 W. Spring St. Columbus, OH 43215

Note: If you work for a self-insuring employer, submit this form to your employer's workers' comp manager.

Injured worker information

First name, middle initial, last name	Date of injury/disease	Social Security number	Date of birth

Mailing address; add apartment number or P.O. Box, if applicable	City	State	ZIP code

Sex ☐ Male ☐ Female	Email address	Home phone number	Cell phone number

Employer name	Employer address	City	State	ZIP code
STOW MUNROE FALLS CITY SCHOOLS	**4350 ALLEN RD, STOW, OH, 442241032**	**STOW**	**OH**	**442241032**

Was the injured worker hired through a temp agency? ☐ Yes ☐ No If yes, name of temp agency	Mark the days of the week you usually work ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat	Regular work hours(include a.m. p.m) From To

Date hired	Job title	State where hired	State where supervised	Wage rate; $ per hour	Number of hours scheduled to work the week of this injury

Work number for call-offs (Number injured worker calls to reach supervisor)	Part(s) of body affected (For example: Left knee, right index finger)

Accident description (Describe the sequence of events that directly caused the injury or death.)	**Will the incident cause the injured worker to miss 8 or more days from work?** ☐ Yes ☐ No

Injured worker start time ☐ am ☐ pm	Time of injury ☐ am ☐ pm	Date employer notified	Was any part of a workday missed due to the injury? ☐ yes ☐ No	Date last worked	If the injured worker has returned to work, provide thedate

Was the place of the accident or exposure on employer's premises? ☐ Yes ☐ No If no, give accident location, street address, city, state, and ZIP code.	Was injured worker hospitalized overnight? ☐ Yes ☐ No

Initial treatment date	Health-care office/Facility name	Treating physician/Provider name	Telephone number	Fax number

Health-care office/Facility street address	City	State	ZIP code

If the injury resulted in death, answer the following.

Date of death Decedent's marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Decedent's number of dependents

To be completed by the injured worker

By signing this form, I

- **Elect to only receive compensation, benefits, or both provided for in this claim under Ohio's workers' compensation laws.**
- **Understand, waive, and release my right to receive compensation and benefits under the workers' compensation laws of another state for the injury, occupational disease, or death resulting from an injury or occupational disease for which I am filing this claim.**
- **Confirm I have not received compensation and benefits under the workers' compensation laws of another state for this claim, and I will notify BWC immediately upon receiving any compensation or benefits from any source for this claim**
- **Will not file and have not filed a claim in another state for the injury, occupational disease, or death resulting from an injury or occupational disease for which I am filing this claim.**

Furthermore, I understand that:

- Upon request, my treating providers may submit to BWC, my employer, my employer's managed care organization or qualified health plan, or their authorized representatives medical, psychological, psychiatric, or vocational documentation relating causally or historically to physical or mental injuries relevant to this claim and necessary for me to obtain medical services, benefits, or compensation.
- Proper administration of this claim may require BWC to review and share with the employers of record, their authorized representatives, or my authorized representative any information or record maintained in this claim, or in my previous or future claims
- Information or records maintained in my previous or future claims may affect decisions made in this claim.
- Any person who obtains compensation or benefits from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false statements, or accepting compensation or benefits to which he or she is not entitled, is subject to felony criminal prosecution for fraud (Ohio Revised Code 2913.48).

I certify that I have read, understand, and agree to the above statements and the information contained on this form is true and accurate to the best of my knowledge

Injured worker signature	Date

To be completed by the treating provider

Diagnosis(es)-narrative description including as appropriate, the location and body part, and ICD code(s). **Important:** If there is an injury, list the condition or disease, not the symptoms or exposure. For example, "sprain right knee" not "pain right knee", "toxic effect of ammonia" not "exposure to ammonia", "contusion to the head" not "headache".

Initial treatment date	Are the medical conditions you have listed above causally related to the reported work-related accident or occupational disease? ☐ Yes ☐ No Are you the physician of record? ☐ Yes ☐ No

Treating physician/Provider's name (Print)	Treating physician/Provider's signature	BWC provider number	Date

To be completed by the employer

Employer name	Employer county	Phone number	Fax number	Email address
STOW MUNROE FALLS CITY SCHOOLS	**SUMMIT**	**3306895415**		

Employer policy number	Federal ID number	Injured worker is (Check box, if applicable.) ☐ Owner/Sole proprietor ☐ Partner ☐ Individual incorporated as a corporation
37751851000	**34-6002738**	

For all employers: ☐ Certification – I certify the facts in this application are correct and valid. ☐ Rejection - I reject the validity of this claim for the reason(s) listed below.

For self-insuring employers only: ☐ Medical only ☐ Lost time

Clarification – I clarify and allow the claim for the condition(s) below.

Employer signature and title	Date

To be completed by the submitter if the form is completed by someone other than the injured worker, treating physician, or employer

Signature of person completing this form	Date

STOW-MUNROE FALLS ACCIDENT REPORT FORM

- - - To report an accident or injury involving any Employee, Student or Non-Employee - - -

PERSONAL INFORMATION (Complete all that are applicable in INK)

☐ **Employee**
☐ **Non-Employee** ☐ **Student - Grade** _____ **Date of this Report:** _____

Name (Print): _____ **Date of Birth:** _____ **Gender:** ☐ **Female** ☐ **Male**

Home Address: _____ **City:** _____ **Zip Code:** _____

Work Phone: _____ **Home Phone:** _____ **Alt. Phone:** _____

Job Title: _____ **Building:** _____

ACCIDENT INFORMATION (Complete all that are applicable in INK)

***Accident Date*:** _____ **Time:** _____ **am** ☐ **pm** ☐ **Time Shift Began:** _____ **am** ☐ **pm** ☐

Location of Accident (Be specific):

Regular Work Hours	
From _____ ☐am ☐pm	To _____ ☐am ☐pm

What was being done <u>before</u> the accident occurred? (Attach separate sheet if necessary)

What happened? (Attach separate sheet if necessary)

Was this part of normal routine? YES ☐ **NO** ☐ **Body part(s) affected or injured:** _____

Type of injury or illness: _____ **What object or substance directly harmed you?** _____

Witnesses (Name & Phone):

Report prepared by (if different from the injured person): _____ **Phone:** _____

- *If you have been exposed to human blood or body fluids other than your own, refer to Stow-Munroe Falls CSD Blood and Body Fluid Exposure protocol and/or contact the Business Office at 330-689-5413 for instruction*

INJURED PERSON SIGNATURE: _____ **DATE:** _____

SUPERVISOR / PERSON-IN-CHARGE

This accident was reported to me on: Date: _____ **Time:** _____ **am** ☐ **pm** ☐

Is further research required? YES ☐ **NO** ☐ **Supervisor/Person-in-Charge Signature:** _____

PRINT Name: _____

HEALTH CARE PROVIDER

Treated by School Nurse? YES ☐ **NO** ☐ **If No, treated by?** _____ **Location:** _____

Diagnosis, assessment or first aid: _____

Is this a re-aggravation of previous injury? Yes No Date of initial injury: _____ **Lost time or restricted Duties? Yes No**

<u>Original sent to</u>: Business Office ☐ **<u>Copies sent to</u>: Principal** ☐ **PIC** ☐ **Supervisor** ☐ **Injured Person** ☐

ATTENTION: This form contains information regarding health issues and will be used in a manner that protects the privacy of injured parties to the extent possible while the information is being used for occupational safety and health purposes. All questions are to be directed to the Business Office.

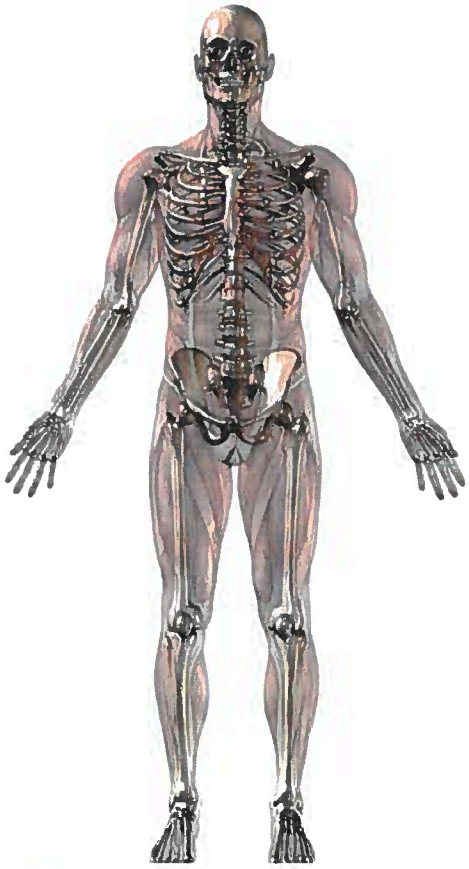
STOW MUNROE FALLS CITY SCHOOLS

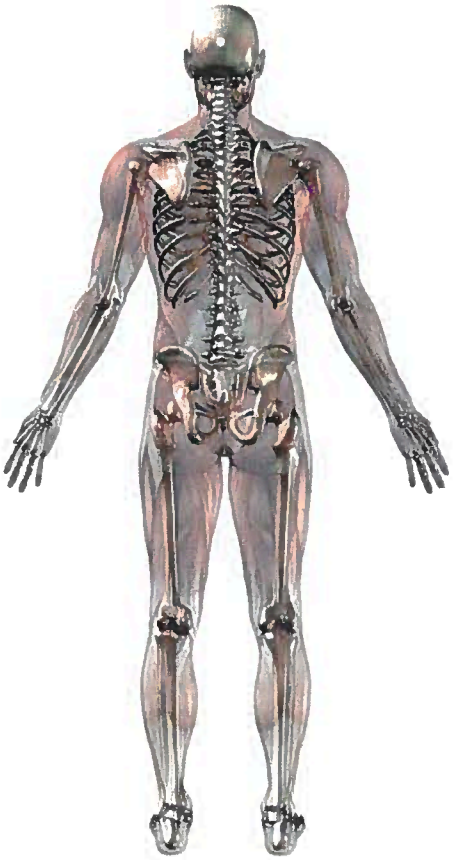
ANATOMY FORM

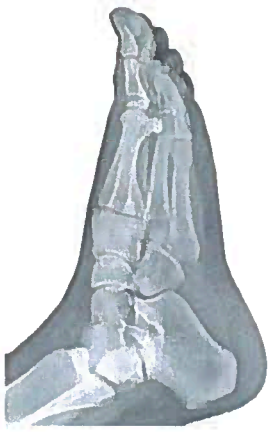
Instructions for Employee:

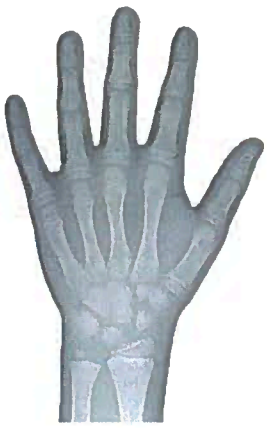
Please circle the injured body part(s) then sign and date this form.

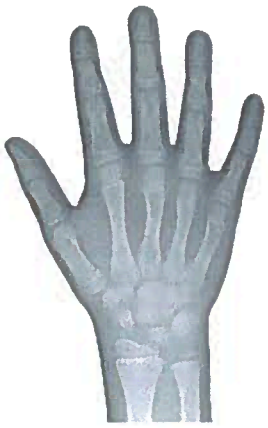
Signature of Claimant _____ Date _____











Ohio | Bureau of Workers' Compensation

Physician's Report of Work Ability (MEDCO-14)

Instructions

- Use this form to provide detailed information about the injured worker's ability to work. Add comments to Section 4 or attach additional information as necessary. BWC uses the information to support a request for temporary total compensation.
- The treating physician must submit this form each time they see the injured worker unless they:
  - Have been awarded permanent and total disability.
  - Have returned to work without restrictions within seven days of the injury.
  - Are being treated after the treating physician has released them to their former position of employment (i.e., full duty job) held on the date of injury without restrictions.
- While you may use an equivalent physician-generated document (e.g., office notes, treatment plan) to the MEDCO-14, it must contain, at a minimum, the required data elements. If you've previously submitted equivalent data, indicate the date of the report on the form (e.g., 5/15/2021, office note).

Note: Physician assistants and nurse practitioners may complete this form; however, they may only certify temporary disability for the first six weeks after the date of injury. Subsequent periods of temporary disability require a co-signature by the treating physician.

- Fax form to the managed care organization if the employer is state-fund or to the employer if self-insured.
- **Important:** Failure to provide complete information may delay compensation payments to the injured worker.

Injured worker name	Claim number	Date of injury

Date of ***last*** appointment/examination	Date of ***this*** appointment/examination	Date of ***next*** appointment/examination

1 Submission type (Select one of the options below.)

☐ Initial MEDCO-14. ***Proceed to Section 2.***
☐ Subsequent MEDCO-14, **no** changes ***Proceed to Section 6.***
☐ Subsequent MEDCO-14, **with changes.** Check the appropriate box **"Reporting changes from the last evaluation" or "No changes" in each** section.

2 Job description and work status ☐ Reporting changes from last evaluation ☐ No changes

- **Have you reviewed the injured worker's job description?** ☐ Yes ☐ No
  - **If yes,** who provided the job description ☐ Injured worker ☐ Employer ☐ MCO/BWC
- Does the injured worker have any physical or health restrictions **related to the allowed conditions in the claim** on the date of this exam? ☐ Yes ☐ No
  - **If yes,** are the restrictions: ☐ Permanent? ☐ Temporary?
  - **If no,** check the box to indicate the injured worker is released to return to full duty as of the date of this exam. ☐ ***Proceed to Section 6.***
- If there are restrictions, can the injured worker return to their full duty job held on the date of injury as of the date of this exam? ☐ Yes ☐ No
  - **If yes, *Proceed to Section 6.***
  - **If no,** provide date restrictions began ____/____/____ and estimated full duty return-to-work date ____/____/____. ***Proceed to Section 3.***

3 Disability information ☐ Reporting changes from last evaluation ☐ No changes

Complete the chart below for all **work-related allowed conditions being treated**.

Narrative description of the **work-related allowed condition**	Site/Location if applicable	ICD code	Is the condition preventing full duty release to the job injured worker held on the date of injury?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

List all other conditions that **impact treatment** of the conditions listed above (e.g., co-morbidities or not yet allowed conditions).

Injured worker name	Claim number	Date of injury

4 Abilities, clinical findings, and recovery progression ☐ Reporting changes from last evaluation ☐ No changes

- Is the Injured worker taking prescribed medication for the allowed conditions that may be a safety hazard? ☐ Yes ☐ No
- Dominant hand: ☐ Right ☐ Left
- **Circle the injured worker's physical abilities for the activities in the chart below and provide comments as necessary.**

Frequency scale	**Strength level (lbs.)**	**Body side indicator**
N = Never **S** = Seldom 0-1 hour **O** = Occasional 1-3 hours **F** = Frequent 3-6 hours **C** = Constant 6-8 hours	**S** = Sedentary 0-10 **L**= Light 0-20 **M** = Medium 0-50 **H** = Heavy 0-100 **VH** = Very heavy >100	**L** = Left **R** = Right **B** = Both *Indicate **limitations ONLY**

Activity	Frequency	Activity	Strength	Frequency	Activity	Side
Sit	N S O F C	Floor lift (0-17")	S L M H VH	N S O F C	Front/Lateral reach	L R B
Stand/Walk	N S O F C	Knee lift (18-29")	S L M H VH	N S O F C	Overhead reach	L R B
Climb stairs	N S O F C	Waist lift (30-36")	S L M H VH	N S O F C	Wrist flex/extension	L R B
Squat/Kneel	N S O F C	Chest lift (37-60")	S L M H VH	N S O F C	Grasp	L R B
Crawl	N S O F C	Overhead lift (>60")	S L M H VH	N S O F C	Finger manipulation	L R B
Twist	N S O F C	Push/Pull	S L M H VH	N S O F C	Keyboarding	L R B
Bend/Stoop	N S O F C	Carry	S L M H VH	N S O F C	Operate foot controls	L R B

- Injured worker can work _____hours per day and _____ hours per week.
- Are there any functional restrictions based only on the allowed psychological conditions? ☐ Yes ☐ No
  - If yes, describe any functional restrictions in comments below and reference the MEDCO-16 as needed.
- Provide your clinical and objective findings supporting your medical opinion. List barriers to return to work, reason(s) for delayed recovery, and proposed treatment plan (e.g., modalities, therapies, surgery), including estimated duration of each treatment or indicate if all or part of this information is in office notes (include date(s) of notes).

Comments:

Health and Behavioral Assessment: (HBA evaluates cognitive, emotional, social, and behavioral barriers that might impact physical health problems and treatments which are associated with the allowed physical injury in the claim.)

- **Is the injured worker's recovery not progressing**, or progressing slower than expected? ☐ Yes ☐ No
- Do cognitive, emotional, social, or behavioral barriers exist that may be interfering with expected healing? ☐ Yes ☐ No

Vocational rehabilitation is a voluntary program for an eligible injured worker who needs assistance to remain at work or return to work. Is the injured worker currently able to participate in a vocational rehabilitation program? ☐ Yes ☐ No

5 Maximum medical improvement (MMI) status ☐ Reporting changes from last evaluation ☐ No changes

MMI is a treatment plateau (static or well-stabilized) at which no fundamental functional or physiological change can be expected within reasonable medical probability, in spite of continuing medical or rehabilitative procedures. Has the work-related injury(s) or occupational disease reached MMI based on the definition above? ☐ **Yes** ☐ **No**

- **If yes**, give MMI date: ____/____/____. ***Note:*** *An injured worker may need supportive treatment to maintain his or her level of function after reaching MMI. So, periodic medical treatment may still be requested and, if approved, provided.*

6 Treating physician's signature – mandatory (See exceptions at the top of the form.)

I certify the information on this form 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 be punished, under appropriate criminal provisions, by a fine or imprisonment or both.

Treating physician's **name** (Print legibly.)		Address, city, state, nine-digit ZIP code	
Treating physician's **signature**			
BWC provider (PEACH) number	Date	Telephone number	Fax number

Ohio | Bureau of Workers' Compensation

Authorization to Release Medical Information

Instructions

You can obtain this form online at www.bwc.ohio.gov

- Please print or type.
- List the provider(s) you are authorizing to release medical records in the space indicated on this form.
- **Please sign and date the form, and send it to the customer service office where your claim is located or to your self-insured employer.**

C-101 - Authorization to Release Medical Information: Injured workers should use this form to authorize the release of medical records relative to their work-related injury(s). By signing this form, the injured worker authorizes medical providers who have rendered services relative to the injury to release information to BWC, the Industrial Commission, the employer, the managed care organization (MCO) or qualified health plan (QHP) and any authorized representatives. The form is intended to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), although BWC is exempt from HIPAA requirements.

Injured worker name (first, M.I., last)		Date of injury	Claim number
Address	City	State	Nine-digit ZIP code
Employer name	Employer MCO or QHP		

I, the above-named injured worker, understand I am allowing the Opportunities for Ohioans with Disabilities and the providers (persons or facilities) named here (_____) that attend or examine me to release the following medical, psychological and/or psychiatric information (excluding psychotherapy notes) that are related causally or historically to physical or mental injuries relevant to my workers' compensation claim:

- Pathology slides and immunohistochemical staining results, if applicable;
- Hospital admission history and physical; emergency room reports; hospital discharge summaries; physician office notes; physical therapist, occupational therapist or athletic trainer assessments and progress notes; consultation reports; lab results; medical reports; surgical reports; diagnostic reports; procedure reports; nursing home and skilled nursing facilities documentation; home nursing progress notes; or other listed below.

_____.

I understand I am authorizing the release of this information to the following: the Ohio Bureau of Workers' Compensation (BWC), the Industrial Commission of Ohio, the above-named employer, the employer's managed care organization or qualified health plan and any authorized representatives.

I understand this information is being released to the above-referenced persons and/or entities for use in administering my workers' compensation claim.

This authorization to release medical, psychological and/or psychiatric information shall remain in effect for as long as my workers' compensation claim remains open under Ohio law. I understand I have the right to revoke this authorization at any time. However, I must submit my revocation in writing and file it with BWC or my self-insured employer. My decision to revoke this authorization will be effective, except in the case that any provider referenced above already has relied on my authorization and released information.

I understand the provider(s) referenced above may not make my completing and signing this authorization a condition of my treatment.

I understand the parties I am authorizing the release of information to are exempted from the federal privacy requirements of the Health Insurance Portability and Accountability Act of 1996 as they administer workers' compensation programs. Information disclosed pursuant to this authorization may be redisclosed by them and may no longer be protected by the federal privacy requirements. I understand such redisclosures may include but are not limited to the following:

- A copy of the medical information the employer receives may be forwarded to BWC by the employer;
- A copy of the medical information will be available to me or my physician of record upon request to BWC or to the employer.

Injured worker (or guardian or personal representative) signature	Date

If signed by the injured worker's guardian or personal representative, provide a description of the guardian or personal representative's authority to sign on behalf of the injured worker. _____