



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.

Treatment info.

Employer 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		
Wage rate \$ _____ Per: <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)	
Benefit application release of information – 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 Ohio's 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, the Ohio State Board of Pharmacy, the Ohio Department of Job and Family Services and the Ohio Rehabilitation Services Commission to release medical, psychological, psychiatric, pharmaceutical, vocational and social information. I understand this may include personally identifying 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 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.					
Injured worker signature		Date	E-mail address	Telephone number	Work number ()
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 policy number			Check if <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"/> 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 reason(s) listed below: <hr/>		
			For self-insuring employers only <input type="checkbox"/> Clarification - The employer clarifies and allows the claim for the condition(s) below: <input type="checkbox"/> Medical only <input type="checkbox"/> Lost time		
Employer signature and title				Date	OSHA case number