

First Report of an Injury, **Occupational Disease or Death**

WARNING: By signing this form, I: Any person who obtains compensation from 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 BWC or self-insuring employers by knowingly the injury or occupational disease, or death resulting from an injury or occupational disease, for which I am filing this claim; misrepresenting or concealing facts, making false 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 statements or accepting compensation to which he injury or occupational disease for which I am filing this claim; or she is not entitled, is subject to felony criminal Confirm that I have not received compensation and/or benefits under the workers' compensation laws of another state for this claim, prosecution for fraud. and that I will notify BWC immediately upon receiving any compensation or benefits from any source for this claim. (R.C. 2913.48) Last name, first name, middle initial Social Security number Date of birth Marital status ☐ Single ☐ Married Home mailing address Number of dependents ☐ Female ☐ Divorced ☐ Male ☐ Separated Country if different from USA State 9-digit ZIP code Department name City ☐ Widowed What days of the week do you usually work: Regular work hours Wage rate ☐ Hour ☐ Month ☐ Week □Sun □Mon □Tues □Wed □Thur □Fri □Sat From Per: Year ☐ Other Have you been offered or do you expect to receive payment or wages for this claim from anyone other than the Ohio Bureau Occupation or job title ☐Yes ☐No If yes, please explain. **Educational Service Center of Northeast Ohio** Mailing address (number and street, city or town, state, ZIP code and county) 6393 Oak Tree Blvd., Suite 300 Independence, Ohio 44131 Location, if different from mailing address Was the place of accident or exposure on employer's premises? ☐ Yes ☐ No (If no, give accident location, street address, city, state and ZIP code) Date of injury/disease Time of injury If fatal, give date of death Time employee Date last worked Date returned to work ☐ a.m. ☐ p.m. began work □ a.m. □ p.m Date hired State where hired Date employer notified State where supervised Type of injury/disease and part(s) of body affected Description of accident (Describe the sequence of events that directly injured the employee, or caused the disease or death.) (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 claim, and a twarve and release my right to me for and receive compensation and 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. Date E-mail address Telephone number Work number Injured worker signature Health-care provider name Telephone number Fax number Initial treatment date 9-digit ZIP code Street address Diagnosis(es): Include ICD code(s) Will the incident cause the injured worker to Is the injury causally related to the industrial incident? miss eight or more days of work? ☐ Yes ☐ No ☐ Yes ☐ No 11-digit BWC provider number Date E code Health-care provider signature Employer policy number ☐ Employer is self-insuring 31800051-0 ☐ Injured worker is owner/partner/member of firm ederal ID number Fax number E-mail address Manual number Telephone number (216) 606-1044 (216) 901-4218 ☐ Yes ☐ No Was employee treated in an emergency room? ☐ Yes ☐ No Was employee hospitalized overnight as an inpatient? If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code For self-insuring employers only Certification - The employer Rejection - The employer rejects the validity of this claim for the reason(s) listed below: Clarification - The employer clarifies and allows the claim for the condition(s) below:

Employer signature and title

certifies that the facts in this application are correct and valid.

OSHA case number

■ Lost time

Medical only

Date