

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 Lam filing 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

	im that I have not received compensation and/or benefits under the workers' compensation laws of another state for this claim, hat I will notify BWC immediately upon receiving any compensation or benefits from any source for this claim.						prosecution for fraud. (R.C. 2913.44)			
Last name, first name, middle initial				Social Securit	y number	Marītal status ☐ Single	Date of bir	th		
Home mailing address				Sex Male	☐ Female	☐ Married ☐ Divorced		f dependents		
City				Country if dif	ferent from USA	☐ Separated ☐ Widowed	Departme	nt name		
Wage rate \$ Have you been offered or	Per r	Hour Mo	her		the week do you on Tues \(\)	Ned □Thur □]Fri □Sat	Regular work hours FromTo on or job title		
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of Workers' Compensation Employer name Mailing address (number Location, if different from Was the place of accident (If no, give accident locat Date of injury/disease Date hired Description of accident (If injured the employee, or	and street, city or	town, state, Z	IP code and county							
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Was the place of acciden	nt or exposure on e	mployer's prei	mises? Yes N	lo						
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Date hired		ate where hir		Date emp	loyer notified		Change Blighade	supervised		
Description of accident (I injured the employee, or			that directly			Type of injury/ (For example:		part(s) of body affected ver left back)		
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Completion instructions

(continued)

Health-care provider name	()	()		Initial treatment date
Street address	City		State	9-digit ZIP code
Diagnosistes): Include ICD code(s)				
0				
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	•			
Will the incident cause the injured worker to miss eight or more days of work?	Is the injury causally rela			
E cods	11-dgit	8VVC provider number	O Date	1
Health-care provider signature				
			_	

- Indicate the diagnosis and ICD codes for conditions being treated as a result of the injury.
- Indicate the treating provider's medical opinion that the injury sustained is causally related to the industrial incident, that the injury could result from the method (manner) of the accident, as described by the injured worker. It must be clear that the diagnosis in all probability occurred as a result of the injury.
- Providing a valid E code will enable us to determine the claim more quickly and efficiently.
- Enter the physician's or health-care provider's 11-digit BWC-assigned provider number.
- Signature of the health-care provider completing this form.

40	Employer policy number				Employer is self-insuring Injured worker is owner/partner/member of firm			
9= 1	lephone number	Fax number	E-mail address		Federal ID number	Manual number		
W	M. Mariana and A. Carlos				Was employee hospitalized as an inpatient? ☐ Yes ☐ No			
e II	treatment was given away fro	m work site, provide the fact	ty name, street address, cit	y, sta	te and ZIP code			
oldwa ©	Gertification - The employer Gertification - The employer rejects the validity of this claim for application are correct and valid.				Clarification and allows th	The employer clarifies e claim for the condition(s) below:		
	nployer: signature and title				Date	OSHA case number		

- Enter the employer's BWC-assigned policy number, which is located on the BWC certificate of coverage.
- Enter the four-digit code that indicates the injured worker's job classification, located on the semiannual payroll report.
 - If you do not know the injured worker's manual number, call 1-800-644-6292 and follow the prompts.
- If certification is selected and the claim is allowed, it will promptly be paid. Employers certifying a claim waive both the notice of receipt and notice of first order of compensation.
- If rejection is selected, use the space provided to list the reasons for rejection. Attach additional sheets, if necessary.

- Self-insuring employers that choose to clarify certification may use the space provided. Attach additional sheet, if necessary.
- If this is an OSHA-reportable injury, include the case number assigned by the employer. This form meets OSHA 301 requirements and may be used in lieu of the OSHA 301 when reporting recordable injuries and illnesses to the federal government.

Note:

If your employee misses eight or more days of work, BWC will need wage information for the 52 weeks prior to the date of injury. Submit wage information using employer payroll reports, wage statement (BWC form C-94-A), W-2s, etc.

reatment info

Injured worker and injury/disease/death info.

Completion instructions

(continued)

	Last name, first name, middle initial				ecurity number	Marital status	Date of h	erth		
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Ų į	Injured worker signature		Oate		E-mail address	Telephon	e unuper	Work number		

- Home address: Enter the home address where the injured worker lives. Include the apartment number, if applicable.
 - If the post office does not deliver mail to the home address, list the mailing address instead of the home address.
- Department name: Enter the injured worker's department or area name where he/she normally reports for work.
- Wage rate: Enter the injured worker's rate of pay, and then select how often it is received. (If the pay rate being reported is not hourly, report the gross amount.)
 - If eight or more days of work will be missed, BWC needs wage information for the 52 weeks prior to the date of injury. Submit wage information using employer payroll reports, wage statement (BWC form C-94-A), W-2s, etc.
- What days of the week do you usually work? What are your regular work hours: Enter the days and hours the injured worker normally works.
 - If the days worked vary from week to week, list the number of hours worked in an average week.
- Wages: If you received wages during disability, please explain.
- Occupation or job title: Enter the injured worker's type of occupation or actual job title at the time of injury, occupational disease or death.
- Employer name: Enter the name of the injured worker's employer at the time of the injury, occupational disease or death.
- Date of injury/disease: Enter the date injured worker was injured. OR

If the injured worker contracted an occupational disease, determine which of the following happened most recently:

- · The occupational disease was diagnosed by a medical provider;
- The first medical treatment;
- The injured worker first quit work, due to the occupational disease.

Enter this as the date of occupational disease.

- Date last worked: Enter the last day worked as a result of this injury, occupational disease or death.
- Date returned to work: Enter the date the injured worker returned to work after the injury or occupational disease.
- State where hired: Enter the state where the injured worker was hired by the employer listed on this application.
- Date employer notified: Enter the date the employer was notified of the injury, occupational disease or death.
- State where supervised: Enter the state where the injured workerwas supervised by the employer listed on this application.
- Description of accident: Describe in detail the events that caused the injury, occupational disease or death. Attach additional sheets, if necessary.
- Type of injury/disease and part of body affected: Describe the nature of the injury, occupational disease or death.

Indicate the part(s) of body injured, affected or that caused the death.

Examples:

- · Laceration of first toe, left foot;
- · Sprain of lower right back; etc.

Injured worker signature (injured workers only):
Please read the Benefit application/medical release information before signing and dating this form.





First Report of an Injury, Occupational Disease or Death

This form can be completed and submitted online at www.bwc.ohio.gov

Report your injury by completing all three sections of this form

- Omplete as much of all three sections of this form as possible to reduce the time necessary in determining the claim. If this form is completed by the injured worker at the first visit to a medical provider, the injured worker may give the FROI to the provider to complete the treatment information section. The provider can then submit the FROI to the MCO.
- Deliver, mail or fax the completed document to your employer or your employer's managed care organization (MCO).
- If you do not know your employer's MCO, contact BWC at 1-800-644-6292 and follow the prompts, or use the MCO on BWC's Web site at www. bwc.ohio.gov.
- If you are unable to determine your MCO, mail or fax this form to the BWC customer service office closest to your home. For information on your local customer service office, please visit www.bwc.ohio.gov., or call 1-800-644-6292.

Injured workers employed by a self-insuring employer

- Complete this form and give to your employer.
- Your employer should be able to tell you if he or she is a self-insuring employer.
- If your employer is self-insuring and you file this information with BWC, processing delays may occur.

For assistance in completing this form, call your BWC customer service office Monday through Friday, 8 a.m. - 5 p.m.

Cambridge

61501 Southgate Road Cambridge, OH 43725-9114 Phone: 740-435-4200 Fax: 866-281-9351

Canton

339 E. Maple St., Suite 200 North Canton, OH 44720-2593 Phone: 330-438-0638 Toll free: 800-713-0991

Fax: 866-281-9352

Cleveland

615 Superior Ave. W. Cleveland, OH 44113-1889 Phone: 216-787-3050 Toll free: 800-821-7075 Fax: 866-336-8345

Columbus

30 W. Spring St. Columbus, OH 43215-2256 Phone: 614-728-5416 Fax: 866-336-8352

Davton

3401 Park Center Drive, Suite 100 Dayton, OH 45414-2577 Phone: 937-264-5000 Fax: 866-281-9356

Garfield Heights

4800 E. 131 St., Suite A Garfield Heights, OH 44105-7132 Phone: 216-584-0100 Toll free: 800-224-6446

Fax: 866-457-0590

Cincinnati-Governor's Hill

8650 Governor's Hill Drive Cincinnati, OH 45249-1369 Phone: 513-583-4400 Fax: 866-281-9357

Lima

2025 E. Fourth St. Lima, OH 45804-4101 Phone: 419-227-3127 Toll free: 888-419-3127 Fax: 866-336-8346

Mansfield

240 Tappan Drive, N., Suite A Ontario, OH 44906-1366 Phone: 419-747-4090 Fax: 866-336-8350

Portsmouth

1005 Fourth St.
Portsmouth, OH 45662-4315
Phone: 740-353-2187
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Toledo

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