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.

BWC
Better Workers' Compensation
Built with *you* in mind

Governor Bob Taft
Administrator/CEO James Conrad

First Report of an Injury, Occupational Disease or Death

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.

Last name, first name, middle initial			Social Security number	Marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	Date of birth
Home mailing address			Sex ☐ Male ☐ Female		Number of dependents
City	State	9-digit ZIP	Country if different from USA		Department name
Wage $ _____ Per: ☐ Hour ☐ Month ☐ Week ☐ Year ☐ Other _____			What days of the week do you usually work? ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ No (If no, give accident location, street address, city, state and ZIP code)					
Date of injury/disease	Time of injury _____ ☐ a.m. ☐ p.m.	If fatal, give date of death	Time employee began work _____ ☐ a.m. ☐ p.m.	Date last worked	Date returned to work
Date hired	State where hired		Date employer notified		
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/medical release – I am applying for recognition of my claim under the Ohio Workers' Compensation Act for work-related injuries that I did not purposely inflict. I request payment for compensation and/or medical expenses as allowable. Direct payment(s) to the providers of any medical services are authorized. I understand that I am allowing any provider who attends to, treats or examines me to release all medical, psychological and/or psychiatric information that is causally or historically related to physical or mental injuries relevant to issues necessary to the administration of my workers' compensation claim to the Ohio Bureau of Workers' Compensation, the Industrial Commission of Ohio, the employer listed in this claim, that employer's managed care organization and any authorized representatives. I further authorize the Ohio Rehabilitation Services Commission to release information about my physical, mental, vocational and social conditions that is causally or historically related to physical or mental injuries relevant to issues necessary for the administration of my workers' compensation claim to the aforementioned parties.

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? ☐ Yes ☐ No		Is the injury causally related to the industrial incident? ☐ Yes ☐ No		
Health-care provider signature		11-digit BWC provider number		Date

Employer info.

Employer policy number			Check if ☐ Employer is self-insuring ☐ 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? ☐ Yes ☐ No		Was employee hospitalized overnight as an inpatient? ☐ Yes ☐ No		
If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code				

☐ **Certification** - The employer certifies that the facts in this application are correct and valid.

☐ **Rejection** - The employer rejects the validity of this claim for the reason(s) listed below:

For self-insuring employers only

☐ **Clarification** - The employer clarifies and allows the claim for the condition(s) below:
☐ **Medical only** ☐ **Lost time**

Employer signature and title	Date	OSHA case number

WORKER'S COMPENSATION INJURY QUESTIONNAIRE

Please Print:

Name:_____ Todays Date:_____

Employer's Business Name at time of Accident:_____

Employer's Phone:_____ Employer's Address_____

Occupation:_____
❑Yes ❑No Previous Worker's Compensation Injury? Impairment Rating:_____

Length of time at this job prior to injury:_____
Date of Injury:_____ Time of injury:_____ Last Date Worked:_____

Please explain what you were doing at the time you were injured and how the accident happened (lifting, bending, walking, carrying standing, etc.)_____
_____

When did the pain begin?(please be specific)_____

Where did you first feel it?(please be specific)_____

Was the pain intense at first or did it gradually worsen?_____

REPORT ACCIDENT/ACCIDENT OBSERVER

What date did you report this injury on?_____

Who did you report this injury to?_____Position?_____

Did anyone else observe accident/injury? ❑Yes ❑No If yes, Name:_____
Position:_____

SYMPTOMS FROM ACCIDENT

Did you experience bleeding cuts or bruises? ❑Yes ❑No
If bleeding cuts where?_____ If bruises, where?_____

Please describe how you felt. PLEASE BE SPECIFIC.
Immediately after the accident:_____
Later that ❑Day ❑Night:_____
The next day(s):_____
_____

Check symptoms that have become apparent since the accident/injury:

❑Nervousness	❑Loss of balance	❑Sleeping trouble	❑Headache
❑Neck Pain/Stiffness	❑Loss of smell	❑Toe Numbness	❑Fainting
❑Midback Pain	❑Loss of taste	❑Finger Numbness	❑Anxiety
❑Low Back Pain	❑Loss of memory	❑Cold Hands	❑Seizures
❑Eyes sensitive to light	❑Pins & Needles - Arms	❑Cold Feet	❑Visualdisturbance
❑Pain behind eyes	❑Pins & Needles - Legs	❑Chest Pain	❑Forgetfulness
❑Dizziness	❑Shortness of breath	❑Constipation	❑Blurred Vision
❑Cold sweats	❑Head seems too heavy	❑Diarrhea	❑Double Vision
❑Face flushed	❑Irritability	❑Fatigue	❑Confused
❑Ringing/Buzzing Ears	❑Depression	❑Tension	❑Disoriented
❑Fever	❑Other_____		

MECHANISM OF INJURY:

Please explain the mechanism of the injury *(only fill in those sections that apply to you)*:

FALL:

❑Yes ❑No Did you hit anything when you fell? If yes, what?_____
❑Yes ❑No Were you carrying anything when you fell? If yes, what?_____
How much did it weigh?_____lbs.
❑Yes ❑No Did you twist when you fell? If so, to which side? ❑Left ❑Right
❑Yes ❑No Was the area lighted?

Describe the condition of the area (slippery, graveled, etc.)_____
What part of the body did you fall on?_____
How far did you fall? (In feet) _____
What did you land on?_____

LIFT/PULL:

How much did the object weigh?_____lbs.
❑Yes ❑No Did you fall after the injury? If yes, how far?_____
❑Yes ❑No Did you hit anything when you fell? If yes, what?_____
❑Yes ❑No Were you twisting when you were lifting/pulling? If yes, to which side? ❑Left ❑Right

How far off the ground did you have the object before the pain started?_____
❑Yes ❑No Did you drop the object when the pain started?
❑Yes ❑No Did it land on you? Where?_____
Did you lift with your ❑Legs ❑Back ❑Other_____

BEND:

❑Yes ❑No Were you lifting when you were bent over? If yes, how much did the object weigh?_____lbs.
How far were you bent over?_____
❑Yes ❑No Did you fall when the pain started? How far?_____
❑Yes ❑No Were you twisting when you bent forward? Toward which side? ❑Left ❑Right
❑Yes ❑No Did you land on anything? If so, what?_____

WORK STATUS HISTORY:

❑Yes ❑No Have you lost time from work as a result of this new injury? If yes, please give dates:___
_____
❑Yes ❑No Have you gone back to work? When:_____
If yes, status or work: ❑Modified ❑Regular
List restrictions you have been placed on:_____
If you have gone back to work, list activities that are:
PAINFUL:_____
DIFFICULT:_____
❑Yes ❑No If you are currently on disability (time loss), do you want to go back to work doing your regular job?
If no, why not?_____
❑Yes ❑No Are there any problems you have with a fellow employee, supervisor, or manager that needs to be discussed? If yes, please explain:_____
_____

FIRST DOCTOR/HOSPITAL/CLINIC:

❑Yes ❑No Were you hospitalized as a result of this accident? If yes, where:_____

Doctor 1 Name:_____Date of First Visit:_____

❑Yes ❑No Were you examined? ❑Yes ❑No Were X-rays taken?

What diagnosis did the doctor give you?_____

❑Yes ❑No Were you given treatment? If yes, what type?_____
What benefits did you receive from this treatment?_____
_____
Date of last treatment?_____

❑Yes ❑No Did the doctor refer you to another health professional? If yes, to whom and for what?___
_____

❑Yes ❑No Did you follow the doctor's recommendation? If no, why not?_____
_____

SECOND DOCTOR/CLINIC:

Doctor 2 Name:_____Date of First Visit:_____

❑Yes ❑No Were you examined? ❑Yes ❑No Were X-rays taken?

What diagnosis did the doctor give you?_____

❑Yes ❑No Were you given treatment? If yes, what type?_____
What benefits did you receive from this treatment?_____
_____
Date of last treatment?_____

PRIOR SIMILAR SYMPTOMS:

❑Yes ❑No Did you have any physical complaints just before the accident? If yes, please describe in detail:_____
_____

❑Yes ❑No Have you ever had any prior injuries, accidents, diseases or treatment to the area of your body now affected? If yes, what part was previously injured?_____
_____Date previously injured?_____
Describe previous injury:_____

❑Yes ❑No Were you treated? By whom?_____
Date treatment began:_____Date treatment ended:_____
The last date you felt pain or problems from that previous injury:_____

JOB DESCRIPTION

In terms of an 8 - hour workday: ***Occasionally*** = 33%, ***Frequently*** = 34% to 66%, ***Continuously*** = 67% to 100%

In a typical 8 - hour workday, I (circle the number of hours of activity):

Sit	1	2	3	4	5	6	7	8	Hours
Stand	1	2	3	4	5	6	7	8	Hours
Walk	1	2	3	4	5	6	7	8	Hours

On the job, I perform the following activities:

	Not at all	Occasionally	Frequently	Continuously
Bend/Stoop	❑	❑	❑	❑
Squat	❑	❑	❑	❑
Crawl	❑	❑	❑	❑
Climb	❑	❑	❑	❑
Reach Above	❑	❑	❑	❑
Shoulder Level	❑	❑	❑	❑
Crouch	❑	❑	❑	❑
Kneel	❑	❑	❑	❑
Balancing	❑	❑	❑	❑
Pulling/Pushing	❑	❑	❑	❑

On the job, I lift:	Not at all	Occasionally	Frequently	Continuously
Up to 10 pounds	❑	❑	❑	❑
11 to 24 pounds	❑	❑	❑	❑
25 to 34 pounds	❑	❑	❑	❑
35 to 50 pounds	❑	❑	❑	❑
51 to 74 pounds	❑	❑	❑	❑
75 to 100 pounds	❑	❑	❑	❑

❑Yes ❑No Are you required to bend over while doing any lifting?

❑Yes ❑No Are your feet used in repetitive movements, such as operating foot controls?

Do you use your hands for repetitive actions such as:

	Simple Grasping	Firm Grasping	Find Manipulating
Right Hand	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
Left Hand	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No

❑Yes ❑No Are you required to work at unprotected heights? If yes, please describe:_____

_____

❑Yes ❑No Are you required to be around moving machinery? If yes, please describe:_____

_____

❑Yes ❑No Are you exposed to marked changes in temperature and humidity? If yes, please describe:_____

❑Yes ❑No Are you required to drive automotive equipment? If yes, please describe:_____

_____

❑Yes ❑No Are you exposed to dust, flames, and/or gases? If yes, please describe:_____

_____

Please list any additional comments:_____

_____

_____

Patient's Signature:_____ **Date**:_____

S. G. Rabe, D. C. & Associates, Inc.

An injury sustained during the performance of your job must be reported to your immediate supervisor at your place of employment.

In the event that my claim is denied for any reason, I understand that I am responsible for any and all charges incurred as a result of this injury.

Signature: _____ Date: _____