Bureau of Workers' Compensation

Application for Wage Loss Compensation

Instructions

- You must file this completed application when requesting an **initial** payment of wage loss compensation or for any requests for wage loss compensation succeeding a broken period.
- You must also attach copies of current pay stubs, a payroll report with gross earnings or a completed *Employer Report of Earnings for Wage Loss Compensation* (C-94A) when requesting working wage loss.
- You must also attach proof of job search using the *Wage Loss Statement for Job Search* (C-141) or equivalent form when requesting non-working wage loss or working wage loss when job search is required.
- If BWC is processing your claim, fax the completed form to 1-866-336-8352, or send it to the BWC customer service office where your claim is assigned.
- If a self-insuring employer is processing your claim, send this form directly to your employer.

Injured worker demographics: *Complete this section in its entirety then proceed to section 2.*

1	Injured worker name	Date of injury		Claim number
	Address	City	State	Nine-digit ZIP code
	Occupation or job title at time of injury		Email address	Contact number

Type of wage loss requested

2 I am requesting (Check all that apply and provide an end date if you are applying for a closed period).

☐ Working wage loss benefits from _____ to _____. *Complete and proceed to section 4.*

☐ Non-working wage loss benefits from _____ to _____. *Complete and proceed to section 3.*

Registration with employment services (You must attach proof of registration) *Complete and proceed to section 4.*

3 I have registered with the Ohio Department of Jobs and Family Services or the applicable employment services agency in my residential state:

☐ Yes ☐ No

If you have registered in a state other than Ohio, which state? _____

Benefits received during the period of compensation requested: *Complete this section in its entirety then proceed to section 5.*

	Type of benefit	Receiving	Beginning date of benefit
4	Wage replacement	☐ Yes ☐ No	
	Non-occupational and sickness benefits	☐ Yes ☐ No	

Previous work history: Provide your **complete** employment history. Attach additional information to this form if necessary. *Complete this section in its entirety then proceed to section 6.*

	Name of employer	Dates of employment	Position description and list of job duties
5			

Comments (please provide information regarding any other skills, education, or training not mentioned above):

Sought employment with the employer at the time of injury. *Complete this section in its entirety then proceed to section 7.*

6 Check one of the following:

☐ I am presently employed by my employer at the time of my injury;

☐ I have made application with my employer at the time of injury and I was unable to secure employment (proof of application must be attached to this application);

☐ My employer at the time of injury is out of business;

☐ I have not applied with my employer at the time of injury because it would be futile. Please explain _____

_____

Medical documentation supporting restrictions *Complete this section in its entirety then proceed to section 8.*

7 Name of the physician who will be supplying medical documentation supporting restrictions due to the allowed conditions in my claim by completing page two of this application: _____ Phone number: _____

Job search *Complete this section in its entirety then proceed to section 9.*

8 I have not attached job search documentation (C-141 or equivalent form) to this application because:

☐ I have returned to work with the employer at the time of injury;

☐ I am only requesting wage loss for work days missed because of treatment that could not be obtained outside of work hours;

☐ I am a work relief employee receiving public assistance;

☐ Other (please explain) _____

Injured worker's signature

9 I have answered the foregoing questions truthfully and completely. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by BWC or self-insuring employers, or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both. I hereby request payment of wage loss benefits for the period listed and certify that the information listed on this Application for Wage Loss Compensation is correct to the best of my knowledge.
I have also given a copy of this application and any attachments to my employer at the time of injury unless the employer is out of business.

Injured worker signature	Date

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Instructions for the physician

- BWC will use this medical report as part of an application for wage loss compensation.
- Temporary restrictions cannot be certified for a period to exceed 90 days without a new examination of the injured worker.

Injured worker name	Claim number

Please provide the date you last examined/evaluated the injured worker: _____/_____/_____

Restriction period caused by impairment information (all fields required, including site/location if applicable)
Complete the chart below and furnish the narrative description of the diagnosis(es), site/location, if applicable, and ICD code for the allowed work-injury related conditions that are causing restrictions. Please indicate the specific restrictions caused by each of the allowed work-injury related condition. Indicate only the restrictions caused by any impairment resulting from the allowed work-injury related conditions.

Narrative description of the work-related condition:	Site/Location if applicable:	ICD code:	Is the impairment caused by this condition permanent or temporary? If temporary give an opinion as to the expected duration of the restrictions.
			☐ Permanent ☐ Temporary _____/_____/_____
			☐ Permanent ☐ Temporary _____/_____/_____
			☐ Permanent ☐ Temporary _____/_____/_____
			☐ Permanent ☐ Temporary _____/_____/_____
			☐ Permanent ☐ Temporary _____/_____/_____

Please indicate the specific restrictions, physical and/or psychiatric limitation, directly resulting from the allowed conditions in the claim listed above (i.e. cannot lift more than 5 lbs.):

Due to all of the restrictions noted above, how many total hours per day and per week can the injured worker work?

_____ hours per day _____ days per week

Unrelated restrictions

List any additional restrictions the injured worker may have due to unrelated work conditions that impact his/her ability to return to gainful employment:

Treating physician signature - mandatory

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

Name of treating physician completing this report (please print legibly)		Address, City, State, Nine-digit ZIP code
Physician signature (Mandatory)	Date	