



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.

Form with fields for 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

Form with checkboxes for Working wage loss benefits and Non-working wage loss benefits, including start and end dates.

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

Form with checkboxes for Yes/No regarding registration with the Ohio Department of Jobs and Family Services or applicable agency.

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

Table with columns: Type of benefit, Receiving (Yes/No), Beginning date of benefit. Rows include Wage replacement and Non-occupational and sickness benefits.

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.

Table with columns: Name of employer, Dates of employment, Position description and list of job duties.

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.

Form with checkboxes for employment status: I am presently employed, I have made application, My employer is out of business, or I have not applied.

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

Form with fields for Name of the physician and Phone number.

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

Form with checkboxes for job search status: I have returned to work, I am only requesting wage loss, I am a work relief employee, or Other.

Injured worker's signature

Form with text for signature and date, including a statement of truthfulness and a note about providing a copy to the employer.



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.

Table with 4 columns: 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.

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