Ohio | Bureau of Workers' Compensation

Application for Determination or Increase of Percentage of Permanent Partial Disability (C-92)

Claim number

Instructions
Complete this form and fax it to 1-866-336-8352, or send it to your local BWC claims office.

Application designation

I am applying for one of the options listed below.

- ☐ The initial percentage of permanent partial disability (%PPD) — I understand I must attend a BWC exam, and that BWC will evaluate all the conditions allowed in my claim unless noted below.
  Note exclusions, if applicable, here: _____
- ☐ A %PPD for a newly allowed condition in this claim — I understand **if** an exam is scheduled, I am required to attend.
  Please list newly allowed condition(s) here: _____
- ☐ Increase in the %PPD — I believe my medical condition has worsened and my %PPD for this claim has increased. I understand I am required to submit with this application a medical report from my doctor showing evidence of an increase. I understand BWC will only consider an increase for those conditions supported by evidence of new and changed circumstances. I understand **if** an exam is scheduled, I am required to attend.

Injured worker information

Name	Date of injury

Address ☐ Check if this is a new address

City	State	Nine-digit ZIP code

Contact number	☐ Cell ☐ Home	Alternate contact number	☐ Cell ☐ Home

Preferred method of contact
☐ Contact number ☐ Alternate contact number ☐ Email ☐ Other: please specify:

☐ Check here if you need an interpreter to attend the exam.	Email address

Exam availability: Mornings (7 a.m. to 12 p.m.), afternoons (12 p.m. to 5 p.m.)
We will attempt to accommodate your requested exam availability.
WARNING! — BWC may dismiss this application if the injured worker fails to respond to an attempt to schedule an exam or fails to attend the exam

Please check all days of the week and times of the day that you **can** attend an examination.

☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday	☐ Saturday
☐ Morning	☐ Morning	☐ Morning	☐ Morning	☐ Morning	Note - Appointments on this day are available on a limited basis.
☐ Afternoon	☐ Afternoon	☐ Afternoon	☐ Afternoon	☐ Afternoon	
☐ Anytime	☐ Anytime	☐ Anytime	☐ Anytime	☐ Anytime	

- If there are specific dates you cannot attend an examination in the next six weeks, please list them below.
- If you are only available before/after a specific time of day (morning or afternoon), please note that time (e.g., only after 3 p.m.).

Injured worker signature

- I certify the information on this form is true and correct. I understand that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain benefits/compensation as provided by BWC or self-insuring employers, or who knowingly accepts compensation to which that person is not entitled, is subject to criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.
- I certify all the information listed above is current as of the time of the filing of this application.

Signature of injured worker/injured worker representative	Date

Authorized to receive workers' compensation check

Injured worker representative name	Representative ID number

- I hereby authorize and direct BWC to mail directly to my attorney the compensation payment in the above numbered claim any accrued monetary award generated by this application.
- This authorization does not give my attorney the authority to cash or endorse a check on my behalf.
- This authorization shall not continue in effect after BWC has paid said award(s) on the original application noted above unless there is a subsequent hearing, appeal or reconsideration after payment was made.
- This authorization is not valid if it is filed beyond 18 months from the date of my signature.

Signature of injured worker	Date