Ohio | Bureau of Workers' Compensation

First Report of an Injury, Occupational Disease or Death (FROI)

Instructions

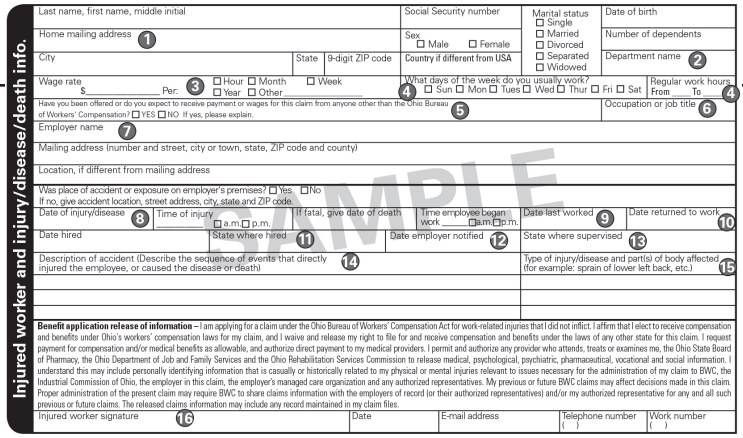
To expedite your claim, you can complete and submit this form online at **www.bwc.ohio.gov.**

- If submitting the hard copy form, complete as much of this form as possible to reduce the time necessary for BWC to determine the claim.
- If you complete this form at your first visit to a medical provider, the provider should complete the treatment information section. The provider can then submit the FROI to the managed care organization (MCO).
- You should also report this injury to your employer.

Where do I file the hard copy FROI?

For injured workers whose employer is self-insured: Send the form to your self-insuring employer. If you are not sure if your employer is self-insured, ask your employer.

For all other injured workers: Fax the form to 1-866-336-8352, or send it to your local BWC customer service office.



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 (1) | Sex ☐ Male ☐ Female | Number of dependents

City | State | 9-digit ZIP code | Country if different from USA | Department name (2)

Wage rate $_____ Per: (3) ☐ Hour ☐ Month ☐ Week ☐ Year ☐ Other _____ | What days of the week do you usually work? (4) ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat | Regular work hours From ____ To ____ (4)

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. (5) | Occupation or job title (6)

Employer name (7)

Mailing address (number and street, city or town, state, ZIP code and county)

Location, if different from mailing address

Was 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 (8) | Time of injury _____ ☐ a.m. ☐ p.m. | If fatal, give date of death | Time employee began work _____ ☐ a.m. ☐ p.m. | Date last worked (9) | Date returned to work (10)

Date hired | State where hired (11) | Date employer notified (12) | State where supervised (13)

Description of accident (Describe the sequence of events that directly injured the employee, or caused the disease or death) (14) | Type of injury/disease and part(s) of body affected (for example: sprain of lower left back, etc.) (15)

Benefit application release of information – I am applying for a claim under the Ohio Bureau of Workers' Compensation Act for work-related injuries that I did not inflict. I affirm that I elect to receive compensation and benefits under Ohio's workers' compensation laws for my claim, and I waive and release my right to file for and receive compensation and benefits under the laws of any other state for this claim. I request payment for compensation and/or medical benefits as allowable, and authorize direct payment to my medical providers. I permit and authorize any provider who attends, treats or examines me, the Ohio State Board of Pharmacy, the Ohio Department of Job and Family Services and the Ohio Rehabilitation Services Commission to release medical, psychological, psychiatric, pharmaceutical, vocational and social information. I understand this may include personally identifying information that is casually or historically related to my physical or mental injuries relevant to issues necessary for the administration of my claim to BWC, the Industrial Commission of Ohio, the employer in this claim, the employer's managed care organization and any authorized representatives. My previous or future BWC claims may affect decisions made in this claim. Proper administration of the present claim may require BWC to share claims information with the employers of record (or their authorized representatives) and/or my authorized representative for any and all such previous or future claims. The released claims information may include any record maintained in my claim files.

Injured worker signature (16) | Date | E-mail address | Telephone number ( ) | Work number ( )

SAMPLE

Injured worker and injury/disease/death info.

(1) Home address: Address where you live, including the apartment number, if applicable.
- If the post office does not deliver mail to the home address, list the mailing address.

(2) Department name: Enter the department where you normally report for work.

(3) Wage rate: Enter your rate of pay, then select how often you receive it. (If the pay rate reported is not hourly, report the gross amount.)
- If you will miss eight or more days of work, BWC needs wage information for the 52 weeks prior to the date of injury.

(4) What days of the week do you usually work? What are your regular work hours: Enter the days and hours you normally work.
- If the days worked vary from week to week, list the number of hours worked in an average week.

(5) Wages: If you received wages during disability, please explain.

(6) Occupation or job title: Enter the type of occupation or job title at the time of injury, occupational disease or death.

(7) Employer name: Enter the name of your employer at the time of the injury, occupational disease or death.

(8) Date of injury/disease: Enter the date you were injured, or if you 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.
For death claims, enter the injured worker date of death.

(9) Date last worked: Enter the last day worked as a result of this injury, occupational disease.

(10) Date returned to work: Enter the date you returned to work after the injury or occupational disease.

(11) State where hired: Enter the state where the employer listed on this application hired you.

(12) Date employer notified: Enter the date that you notified the employer of the injury, occupational disease or death.

(13) State where supervised: Enter the state where the employer listed on the application supervised you.

(14) Description of accident: Describe in detail the events that caused the injury, occupational disease or death.

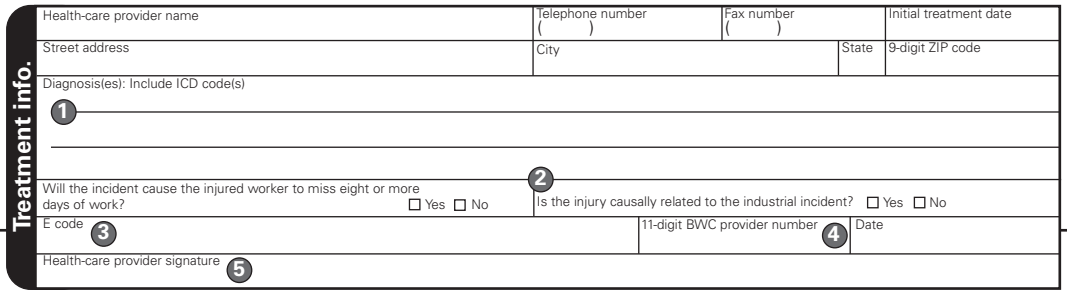
(15) Type of injury/disease and part of body affected: Describe the nature of the injury, occupational disease or death. Indicate the part(s) of body injured, affected or that caused the death.

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

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

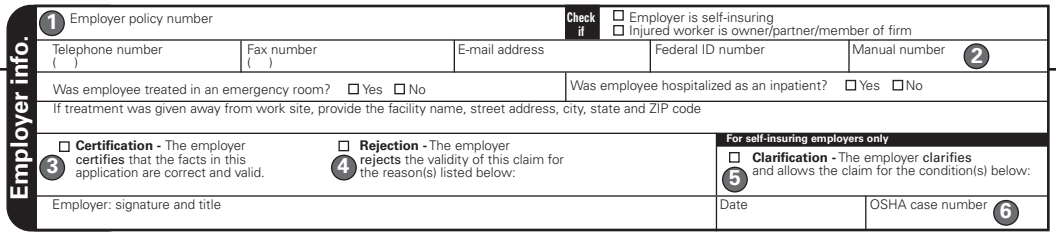
Completion instructions

(continued)



Treatment info.

1. Indicate the diagnosis and ICD codes for conditions treated as a result of the injury.
2. 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.
3. Providing a valid E code will enable us to determine the claim more quickly and efficiently.
4. Enter the physician's or health-care provider's 11-digit BWC-assigned provider number.
5. Signature of the health-care provider completing this form.



Employer info.

1. Enter the employer's BWC-assigned policy number, which is located on the BWC certificate of coverage.
2. Enter the four-digit code that indicates the injured worker's job classification.
   - If you do not know the injured worker's manual number, call **1-800-644-6292,** and follow the prompts.
3. If you select certification, and BWC allows the claim, BWC will promptly pay it. Employers certifying a claim waive both the notice of receipt and notice of first order of compensation.
4. If you select rejection, use the space provided to list the reasons for rejection. Attach additional sheets, if necessary.
5. Self-insuring employers that choose to clarify certification may use the space provided. Attach additional sheets, if necessary.
6. If this is an Occupational Safety and Health Administration (OSHA)-reportable injury, include the case number assigned by the employer. This form meets OSHA 301 requirements.You may use it 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's Employer Report of Employee Earnings), W-2s, etc.

Ohio | Bureau of Workers' Compensation

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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 I am filing this claim;**
- **Confirm that I have not received compensation and/or benefits under the workers' compensation laws of another state for this claim, and that I will notify BWC immediately upon receiving any compensation or benefits from any source for 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 or she is not entitled, is subject to felony criminal prosecution for fraud.
(R.C. 2913.48)

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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 code | Country if different from USA | Department name

Wage rate $ _____ 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 | State where supervised

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)

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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

E code | 11-digit BWC provider number | Date

Health-care provider signature

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