



The employer must complete this form in its entirety and fax it to 1-614-621-3437. The form is available online at www.bwc.ohio.gov.

Claimant information		
Claimant name	Date of injury	Claim number
Employer information		
Employer name	Employer policy number	
Address		
City	State	ZIP code
Email address, if available	Phone number	

Representative information		
*Your representative must have a BWC representative identification number prior to being designated as an authorized representative.		
Representative/Firm name		
Representative BWC ID number*	Phone number	
Representative street address		
City	State	ZIP code
Email address, if available		

Authorization	
I hereby authorize the above representative to represent me in the above claim before the Ohio Bureau of Workers' Compensation and the Industrial Commission of Ohio. This authorization also entitles this representative to automatically receive correspondence generated in the above claim file.	
Signature of employer official granting this authorization	Printed name
	Date of authorization