Bureau of Workers' Compensation

Application for Transitional Work Bonus Program

Submit the form to BWC in one of the following ways.

Online: bwc.ohio.gov

Email: memployerprogramunit@bwc.state.oh.us

Fax: 614-621-1405

Mail: Ohio Bureau of Workers' Compensation
Attn: Employer Programs
30 W. Spring St., 22nd
Columbus, OH 43215-2256

Important: If you fax or mail the form to BWC, be sure to sign and date it. BWC cannot process it without a signature.

Employer information

Name of employer and DBA	Federal tax ID number	BWC policy number

Address

City	State	ZIP code

Employer contact for Transitional Work Bonus Program	Phone number

Email address for Transitional Work Bonus Program contact	Total number of employees reported under this policy number

Private employers: The last business day in May for the July 1 – June 30 program period
Public employer taxing district: The last business day in November for the Jan. 1 – Dec. 31 program period

Eligibility requirements

A company applying for the Transitional Work Bonus Program must have one of the following.

- A transitional work plan developed with a previous BWC grant.
- A company-created transitional work plan.
- A copy of the company's transitional work plan from its human resource manual or employee handbook.
- A signed letter from a company officer stating the employer has a transitional work plan or is in the process of developing a BWC Transitional Work Grant plan.

BWC will automatically renew the employer for each subsequent program period provided the employer meets all eligibility requirements. While participating in the Transitional Work Bonus Program, you should verify other BWC programs compatible with it. You may participate in more than one BWC program. However, only certain programs may be combined in the discount calculation. Reference the compatibility chart found in Ohio Administrative Code (OAC) 4123-17-74.

I hereby certify that my company is applying for the Transitional Work Bonus Program pursuant to OAC 4123-17-55(D). I also certify my company will meet, at minimum, the requirements associated with successfully using my company's approved transitional work program to return my injured employees to work. I understand that if my company does not meet the requirements, I agree to repay any benefits received. Also, I certify this information is accurate and, if not, may subject my company and myself to civil and criminal penalties.

Name of designated representative certifying intent to comply and willingness to pay back bonus for non-compliance.

Owner/Partner/Officer name	Title

Signature X	Date signed