



Instructions

Complete this form or an equivalent form for every offer of transitional work made to an employee who returns to work with restrictions with a date of injury during the bonus period. Fax the completed form to your managed care organization (MCO). Use the MCO fax number on page two.

Employer information		
Name of company	Employer's phone number	Policy number
Name of employee		Claim number
Date of injury	Job title	
Transitional work offer		
On _____ your physician of record/treating physician _____		
Date	Physician name	
released you to return to work with restrictions. We offer you the opportunity to participate in our transitional work plan in accordance with the restrictions from your physician beginning _____		
Program begin date		
<input type="checkbox"/> Despite a release to work with restrictions you can work in your job of injury without accommodations.		
Employer acknowledgement 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, imprisonment, or both.		
Printed name of employer		Title
Signature of employer X		Date signed
<input type="checkbox"/> Employee agreement to participate in transitional work activities <input type="checkbox"/> Employee refusal to participate		
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, imprisonment, or both.		
Printed name of employee		
Signature of employee X		Date signed
Agreement verification		
Complete this section only if you cannot obtain the employee signature after they successfully return to work for one of the reasons stated below.		
<input type="checkbox"/> Communication barrier <input type="checkbox"/> Refuse to sign <input type="checkbox"/> Terminated <input type="checkbox"/> Seasonal <input type="checkbox"/> Quit <input type="checkbox"/> Student/Intern		
<input type="checkbox"/> Other _____		
Attach employee timesheet/pay stub to verify actual return to work.		



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Fax this form to the appropriate MCO listed below.

MCO fax numbers to submit medical information		
Minute Men OhioComp	216-426-0651	888-644-7339
3-HAB	513-221-2008	800-869-1872
AultComp MCO Inc.	330-830-4900	877-738-0058
CareWorks		888-711-9284
CompManagement Health Systems Inc.		800-334-4229
Comp One	330-259-0095	877-283-0921
CorVel OhioMCO, Inc.		877-677-6756
GENEX Care for Ohio		888-275-9719
Health Management Solutions	614-799-0869	888-303-6294
Occupational Health Link	614-825-1459	888-240-6381
Sheakley UniComp	513-326-8005	888-626-2667
Spooner Medical Administrators, Inc.	440-899-2411	800-542-9480