



This *Request for Temporary Total Compensation (C-84)* is the application you complete to request temporary total disability benefits.

You must complete the entire form and sign it. It is your responsibility to secure supporting medical documentation from your treating provider for the requested period of disability using the MEDCO-14 form or equivalent documentation. You must complete this form every time you make a request for an initial period of temporary total compensation or an extension of an existing period of temporary total compensation.

Instructions	
Section 1	Injured worker demographics: BWC will use the address provided to mail all correspondence to you. A home and/or cell phone number is helpful if we need to contact you. Providing your email address allows you to communicate with your claims specialist electronically, if you choose to do so.
Section 2	Disability information: Please mark if this current period of disability is a new period of disability or an extension. If this is an application for a new period of disability, please list the last day you worked. For both new periods and requests for extensions of disability, list all providers currently treating you for this claim.
Section 3	Employment information: BWC will use this information to help facilitate your return to work and ensure proper payment.
Section 4	Vocational rehabilitation information: BWC will use this information to help facilitate your return to work.
Section 5	Benefits/earnings received or requested during the period of disability: Indicate if you have received any of the listed benefits. If you answer yes to any of the benefits on the list, provide the requested information.
Section 6	Injured worker signature: Please sign and date this form when requesting temporary total disability compensation. If you cannot sign, please mark the form and have a witness sign the form next to your mark. Signing the form means you have answered the questions truthfully and completely. It also means you are aware that you are not knowingly making a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by BWC or knowingly accepting compensation to which you are not entitled. Providing false information or concealing information to obtain compensation may subject you to felony criminal prosecution, and may be punished by a fine, imprisonment, or both.

Where do I file the C-84?
For injured workers whose employer is self-insured: If your employer is self-insured, send the form to your employer. If you are not sure if your employer is a self-insuring employer, contact your employer.
For all other injured workers: You may also complete this form online at www.bwc.ohio.gov . If you have completed a hard copy of this form, fax it to 1-866-336-8352, or send it to the BWC customer service office where the claim is assigned.

Where do I find more information or assistance?
For injured workers whose employer is self-insured: Call your employer, or contact BWC's self-insured department at 1-800-644-6292, and listen to the options to reach a customer service representative.
For all other injured workers: Please call 1-800-644-6292, or contact your service office.
You can obtain BWC forms at www.bwc.ohio.gov , by calling 1-800-644-6292 and listening to the options to reach a customer service representative, or at your service office.



Injured worker demographics

Form with fields for Name, Claim number, Date of injury, Address, City, State, Nine-digit ZIP code, Email address (optional), Home phone number, Cell phone number.

Disability information

Form with questions: Is this application requesting a new period of temporary total compensation or an extension? If this is a new period, what was the last date worked due to the current period of work-related disability? List all providers currently treating you for this work-related disability claim.

Employment information

Form with questions: What was your occupation at the time of the injury/disease? Do you have a job to return to? Working includes full or part-time, self-employment, income-producing hobbies, commission work, or unpaid activities that are not minimal and directly earn income for someone else. Are you currently working in any capacity (as defined above)? Have you previously worked in any capacity (as defined above) during this requested period of disability? What do you feel is preventing you from returning to work at this time?

Vocational rehabilitation information

Form with text: Vocational rehabilitation is an individualized and voluntary program for an eligible injured worker who needs assistance in safely returning to work or in retaining employment. This program can be tailored around an injured worker's restrictions and may provide job-seeking skills or necessary retraining. Question: If appropriate, would you consider participating in vocational rehabilitation?

Benefits/earnings received or requested during the period of disability

Table with 3 columns: Type of benefit, Receiving, Beginning date of benefit. Rows include Unemployment, Social Security retirement, Public assistance, Sick leave, Wage/salary continuation, Disability, and Earnings.

Injured worker signature

Form with text: I understand I am not permitted to work while receiving temporary total compensation. I have answered the foregoing questions truthfully and completely. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by BWC or who knowingly accepts compensation 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. Signature and Date fields.