Claim Number:

First Report of an Injury, Occupational Disease or Death

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/she is not entitled, is subject to felony criminal prosecution for fraud.
(R.C. 2913.48)

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			Sex ☐ Male ☐ Female		Number of dependents
City	State	9-digit ZIP code	Country if different from USA		Department name
Wage rate $ _____ Per: ☐ Hour ☐ Year ☐ Month ☐ Other ☐ Week			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 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 _____ ☐ AM ☐ PM	If fatal, give date of death	Time employee began work _____ ☐ AM ☐ PM	Date last worked	Date returned to work
Date hired	State where hired		Date employer notified		

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, etc.)

Benefit Application/Medical Release – *I am applying for recognition of my claim under the Ohio Workers' Compensation Act for work-related injuries that I did not purposely inflict. I request payment for compensation and/or medical expenses as allowable. Direct payment(s) to the providers of any medical services are authorized. I understand that I am allowing any provider who attends to, treats or examines me to release all medical, psychological, and/or psychiatric information that is related causally or historically to physical or mental injuries relevant to issues necessary to the administration of my workers' compensation claim to the Ohio Bureau of Workers' Compensation, the Industrial Commission of Ohio, the employer listed in this claim, that employer's managed care organization, and any authorized representatives. I further authorize the Ohio Rehabilitation Services Commission to release information about my physical, mental, vocational and social conditions that is related causally and historically to physical or mental injuries relevant to issues necessary for the administration of my workers' compensation claim to the aforementioned parties.*

Injured worker signature	Date	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

Health care provider signature	11-digit BWC provider number	Date

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 in-patient? ☐ YES ☐ NO

If treatment was given away from worksite, provide the facility name, street address, city, state, 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 following reason(s) below:

FOR SELF-INSURING EMPLOYERS ONLY
☐ **CLARIFICATION -** The employer **clarifies and allows** the claim for the condition(s) below:

Employer signature and title	Date	OSHA case number

BWC-1101 (Rev. 7/23/2002)
FROI-1 (Combines C-1, C-2, C-3, C-6, C-50, OD-1, OD-1-22)

This form meets **OSHA 301** requirements

Tear off this sheet and return completed form to your employer's managed care organization (MCO) or to your local BWC customer service office.