

(OUT-OF-STATE QUESTIONNAIRE)

BWC LOGO

(Project Use Only - Corr4C)

mm/dd/yy

ADDRESSED TO:
(Employer)

Injured Worker:
Claim Number:
Injury Date:
Claim Type:

Employer Name:
Policy Number:
Employer Status:
MCO Name:
MCO Number:

The Ohio Bureau of Workers' Compensation (BWC) has received an application for benefits for an injury, occupational disease or death filed on behalf of the injured worker. Please answer the following questions concerning your relationship with the injured worker to determine whether the State of Ohio has jurisdiction over this claim. If additional space is needed, attach a separate sheet of paper and include the claim number.

Your response should be returned to the assigned service office and team member indicated below within 14 days from the date of this letter. If we do not receive a response within this time, a decision will be issued based upon the evidence on file.

1. Of which state was the injured worker a legal resident at the time of the injury, exposure or death?
2. In which state(s) did you and the injured worker enter into the contract of employment?
3. In which state is your principal place of business?
4. Do you have a site, terminal, branch office or other business location in Ohio? If so, please provide the name and address.
5. Indicate the city, county and state from which the injured worker was normally paid, supervised and controlled.
6. In which state was the injured worker at the time of the injury, exposure or death?