



Instructions

File this application when requesting an **initial** payment of wage loss compensation.

- Complete the form in its entirety.
- Provide your physician completing this form with a copy of the functional job description at the time of injury and have him or her complete the medical report.
- Provide your employer at the time of injury with all copies and attachments.
- Return the completed form to your local customer service specialist or your self-insuring employer.

You must attach the following when requesting working wage loss (WWL):

- Written proof that employment has been sought with your employer of record;
- Copies of current pay stubs with gross earnings or a completed C-94-A Wage Statement notarized if completed by the injured worker.

You must attach the following when requesting non-working wage loss (NWWL):

- Written proof that employment has been sought with your employer of record.
- Proof of registration with the Ohio Department of Job and Family Services;
- Completed wage loss statement(s) for job search (C-141).

Injured worker name		Date of birth		Claim number	
Address			City		State
					Nine-digit ZIP code
Occupation or job title at time of injury				Injured worker telephone number	
Employer name at time of injury				Employer telephone number	
Address		City		State	Nine-digit ZIP code

I am requesting WWL benefits from _____ to _____

I am requesting NWWL benefits from _____ to _____

Previous work history

This is required for initial applications of WWL and NWWL. Please provide your employment history for each position that contributed to your income at a minimum of the last 10 years. (Please attach additional sheets with this information if necessary.)
BWC may use this information to determine possible referral for vocational rehabilitation and to evaluate job search efforts.

Employer	Dates of employment	Job title	Reason for leaving	Earnings
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Warning

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 self-insuring employers, 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 or imprisonment or both.

I hereby request payment of wage loss benefits for the period listed and certify that the information listed on this Application for Wage Loss Compensation is correct to the best of my knowledge. I have also given a copy of this application with supporting documentation to my employer at the time of injury.

Injured worker signature	Date
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Instructions for the physician

- BWC will use this medical report as part of an application for wage loss compensation.
Please complete this report in its entirety.
Attach additional information that you feel will substantiate this request.
The attending physician must complete and submit this report every 90 days if restrictions are temporary or every 180 days if restrictions are permanent.

Form with fields for Injured worker name, Claim number, Name of physician, Telephone number, Fax number, Address, City, State, Nine-digit ZIP code, Date of this report, Date of last medical examination, and a section for listing allowed conditions.

Indicate only the restrictions caused by any impairment resulting from the allowed conditions. For psychiatric/psychological conditions - attach narrative report outlining restrictions. For physical capacity - denote below.

Form for Total hours during an eight-hour day injured worker can: and Injured worker can: (% of eight-hour day) with checkboxes for activities like Sit, Stand, Walk, Bend, Squat, etc.

Form for Injured worker can lift: (% of eight-hour day) and Injured worker can carry: (% of eight-hour day) with checkboxes for weight categories like Up to 5 lbs, 6-10 lbs, etc.

Form for Use of hands in repetitive action such as: (Simple grasping, Pushing and pulling arm controls, Fine manipulation) and Use of feet in repetitive movements of leg controls.

Form for text input: Based on the allowed conditions of this claim, please list any additional restrictions not specified in the physical capacity section. Are the restrictions temporary/permanent? Duration of the restrictions: from to. Due to the restrictions noted above, how many total hours per day and per week can the injured worker work?

Physician signature (Mandatory) section with a certification statement and fields for Physician name, Physician signature, and Date.