



**Instructions**

- Please print or type.
- Make sure to enter four digits for the year in all date fields.
- If you have any questions, please call the customer service team representative assigned to the claim.
- Follow the distribution list at the bottom of the form.

**Note:** Your acceptance of the injured worker below qualifies your agency for reimbursement of the state portion of its expenditures in accordance with the agreement between the Rehabilitation Services Commission (RSC) and BWC, effective June 10, 1985.

This referral is in accordance with Section 4121.69(B) and (C) of the Ohio Revised Code and the BWC Rule 4123-18-13.

Injured worker name (Last)		(First)	(M.I.)	Social Security number	Claim number
Address					Telephone number ( )
City				State	Nine-digit ZIP code
County	Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth	Date of injury	
Allowable conditions  _____  _____					
Referral source (check one) <input type="checkbox"/> Managed care organization (MCO) case manager <input type="checkbox"/> Vocational rehabilitation consultant					Date of referral
Reason for referral  _____  _____					
MCO name		MCO case manager name		Case manager telephone number ( )	
BWC customer service office		Vocational rehabilitation consultant name		Consultant telephone number ( )	
RSC agency (Check one) <input type="checkbox"/> BSVI <input type="checkbox"/> BVR	RSC counselor name			RSC counselor telephone number ( )	
Address (location of RSC counselor)					
City				State	Nine-digit ZIP code

**Distribution:** BWC claim file, injured worker, injured worker representative, employer, employer representative, MCO