



Instructions

- File this application when requesting an initial payment of wage loss compensation.
Complete the form in its entirety.
Have the attending physician complete the medical report on the back of this application.
Provide your employer of record (employer at time of injury) with all copies and attachments.
Return the completed form to your BWC customer service representative or your self-insuring employer.

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

- Wage loss statement(s) for job search (C-141)(NWWL);
Proof of registration with the Ohio Department of Job and Family Services (ODJFS)(NWWL);
Provide the physician completing this form, a copy of the functional job description at the time of injury (NWWL and WWL);
Written proof that employment has been sought with your employer of record (NWWL and WWL);
Copies of current pay stubs with gross earnings (WWL);
Attach a C-94A, Wage Statement with signed affidavit (NWWL);.

Form with fields for 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 application of WWL and NWWL. Submit subsequent requests for WWL or NWWL on the Wage Loss Statement (C-141).

Table with 5 columns: Employer, Dates of employment, Job title, Reason for leaving, Earnings. Rows numbered 1 to 8.

I hereby certify that the information reported on this Application for Wage Loss Compensation is correct to the best of my knowledge and belief. I have also given a copy of this application and copies of any supporting documentation to my employer of record.

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.

Form with fields for Injured worker signature and Date.

**Instructions for the physician**

- BWC will use this medical report as part of an application for wage loss compensation. You may attach any additional information that you feel will help to substantiate this request.
- This report must be completed by the attending physician and submitted every 90 days if restrictions are temporary or every 180 days if restrictions are permanent.
- Please complete this report as thoroughly and accurately as possible. Attach additional sheet if necessary.

Injured worker name		Claim number	
Name of physician completing this report		Telephone number	Fax number
Address		City	State Nine-digit ZIP Code
Date of this report		Date of last medical examination	

List the allowed conditions in the claim that are causing the restrictions listed below

**Physical Capacity – Identify the injured worker’s physical restrictions caused by any impairments resulting from the allowed conditions in the claim. For psychiatric/psychological condition(s) please attach a narrative report explaining restrictions.**

<b>Total hours during an eight-hour day injured worker can:</b>										<b>Injured worker can: (% of eight-hour day)</b>				
	0	1	2	3	4	5	6	7	8	Never 0%	Occasionally 1%-33%	Frequently 34%-66%	Continuously 67%-100%	
Sit	<input type="checkbox"/>	Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Stand	<input type="checkbox"/>	Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Walk	<input type="checkbox"/>	Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
										Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
										Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

<b>Injured worker can lift: (% of eight-hour day)</b>					<b>Injured worker can carry: (% of eight-hour day)</b>				
	Never 0%	Occasionally 1%-33%	Frequently 34%-66%	Continuously 67%-100%		Never 0%	Occasionally 1%-33%	Frequently 34%-66%	Continuously 67%-100%
Up to 5 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Up to 5 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6-10 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6-10 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11-20 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11-20 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21-25 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21-25 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26-50 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	26-50 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51-100 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	51-100 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Use of hands in repetitive action such as:</b>			<b>Use of feet in repetitive movements of leg controls</b>		
<b>Simple grasping</b>	<b>Pushing and pulling arm controls</b>	<b>Fine manipulation</b>	Right	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Right <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Left	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Left <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Both	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Based on the allowed conditions of this claim, please list any additional restrictions not specified in the physical capacity section. _____	Are the restrictions <input type="checkbox"/> temporary <input type="checkbox"/> permanent
	If temporary give an opinion as to the expected duration of the restrictions: from _____ to _____
Due to the restrictions noted above, how many total hours per day and per week is the injured worker able to work? _____ Hours _____ Days	

**Physician Signature (Mandatory)**

I certify that the above information is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain payment as provided by BWC or who knowingly accepts payment 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.

Physician Signature (Mandatory)	Date	BWC provider number (Mandatory)
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