Give original to supervisor. Take a copy with you when seeking services from a health care provider.

BWC
Better Workers' Compensation
Built with *you* in mind.

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

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
Hamilton County

Mailing address (number and street, city or town, state, ZIP code and county)
138 E. Court Street, Room 707, Cincinnati, OH 45202

Location where injured worker normally reports to work.

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 Ohio | Date employer notified | Full Duty ☐ Restricted Duty ☐

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
33100001-0

Telephone number (513) 946-4703 | Fax number (513) 946-4730 | E-mail address sherrie.dill@hamilton-co.org | Federal ID number 31.6000063 | Manual number 9430

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:

Employer signature and title | Date | OSHA case number

This form meets **OSHA 301** requirements