Ohio | Bureau of Workers' Compensation

First Report of an Injury, Occupational Disease or Death

By signing this form, I:

- Elect to only receive compensation and/or benefits that are provided for in this claim under Ohio workers' compensation laws;
- Waive and release my right to receive compensation and benefits under the workers' compensation laws of another state for the injury or occupational disease, or death resulting from an injury or occupational disease, for which I am filing this claim;
- Agree that I have not and will not file a claim in another state for the injury or occupational disease or death resulting from an injury or occupational disease for which I am filing this claim;
- Confirm that I have not recieved compensation and/or benefits under the workers' compensation laws of another state for this claim, and that I will notify BWC immediately upon receiving any compensation or benefits from any source for this claim.

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 or 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 ☐ Seperated ☐ 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 ☐ Month ☐ Week ☐ Year ☐ Other			What days of the week do you usually work? ☐ Sun ☐ Mon ☐ Tue ☐ 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 **BELMONT COUNTY COMMISSIONER**					
Mailing address(number and street, city or town, state, ZIP code and country) **101 W MAIN ST, ST CLAIRSVLE, OH, 439501264**					
Location, if different from mailing address					
Was the place of accident or exposure on employer's premises? (If no, give accident location, street address, city, state and ZIPcode) ☐ Yes ☐ No					
Date of injury/disease	Time of injury _____ ☐ a.m. ☐ p.m.	If fatal, give date of death	Time employee began work _____ ☐ a.m. ☐ p.m.	Date last worked	Date returned to work
Date hired	State where hired		Date employer notified	State where supervised	
Description of accident (Describe the sequence of events that directly injured the employee, or caused the disease or death.)				Type of inujury/disease and part(s) of body affected (For example: sprain of lower left back)	

Benefit application release of information - I am applying for a claim under the Ohio Bureau of Workers' Compensation Act for work-related injuries that I did not inflict. I affirm that I elect to receive compensation and benefits under Ohio's workers' compensation laws for my claim, and I waive and release my right to file for and receive compensation and benefits under the laws of any other state for this claim. I request payment for compensation and/or medical benefits as allowable, and authorize direct payment to my medical providers. I permit and authorize any provider who attends, treats or examines me, the Ohio State Board of Pharmacy, the Ohio Department of Job and Family Services and the Ohio Rehabilitation Services Commission to release medical, psychological, psychiatric, pharmaceutical, vocational and social information. I understand this may include personally identifying information that is casually or historically related to my physical or mental injuries relevant to issues necessary for the administration of my claim to BWC, the Industrial Commission of Ohio, the employer in this claim, the employer's managed care organization and any authorized representatives. My previous or future BWC claims may affect decisions made in this claim. Proper administration of the present claim may require BWC to share claims information with the employers of record (or their authorized representatives) and/or my authorized representative for any and all such previous or future claims. The released claims information may include any record maintained in my claim files.

Injured worker signature	Date	E-mail Address	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 miss eight or more days of work? ☐ Yes ☐ No		Is the injury casually related to the industrial incident? ☐ Yes ☐ No		
E code		11-digit BWC provider number	Date	
Health-care provider signature				

Employment Info.

Employer policy number **30700001000**	Check If ☐ Employer is self-insuring ☐ Injured worker is owner/partner/member of firm			
Telephone number **(740) 232-1738**	Fax number	E-mail address	Federal ID number **34-6000236**	Manual number
Was employee treated in an emergency room? ☐ Yes ☐ No		Was employee hospitalized overnight as an inpatient? ☐ Yes ☐ No		
If treatment was given away from work site, provider the facility name, street address, city, state and 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 reason(s) listed below:

FOR SELF-INSURING EMPLOYERS ONLY:
☐ **Clarification** - The employer clarifies and allows the claim for the condition(s) below.
☐ **Medical only** ☐ **LostTime**

Employer signature and title	Date	OSHA case number

BWC-1101 (Rev.2/05/2014)
FROI-1 (Combines C-1, C-2, C-3, C-6, C-50,OD-1, OD-1-22)

This form meets **OSHA 301** requirements

BELMONT COUNTY COMMISSIONER

EMPLOYEE'S STATEMENT

I,_____certify that on _____, 20 ____at _____(a.m. or p.m.), I
(Name) (Date) (Time)

sustained an injury to my _____ that occurred as follows:
(Part of Body)

(Describe the incident in detail, stating part of body injured) _____

_____

_____

_____

Has this body part been previously injured? ☐ Yes ☐ No If yes, when? _____

Place incident occurred _____

Did the incident occur while you were working (on the clock)? ☐ Yes ☐ No

Did the incident occur while you were performing your regularly assigned job/duty? ☐ Yes ☐ No

Did the incident occur on employer's property? ☐ Yes ☐ No

Name(s) of Witness(s) _____

Date/Time and to whom the accident was reported to _____

Name of Medical Provider and Treating Physician _____

Provider Address _____ Provider Phone #_____

Employee address _____

Phone Number _____ Date of Hire _____

Building/Occupation_____Supervisor_____

Signature of Employee _____ Date _____

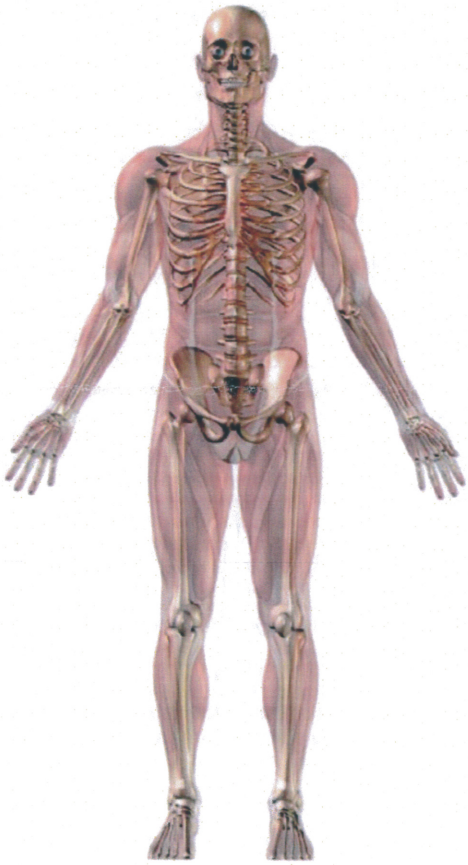
BELMONT COUNTY COMMISSIONER

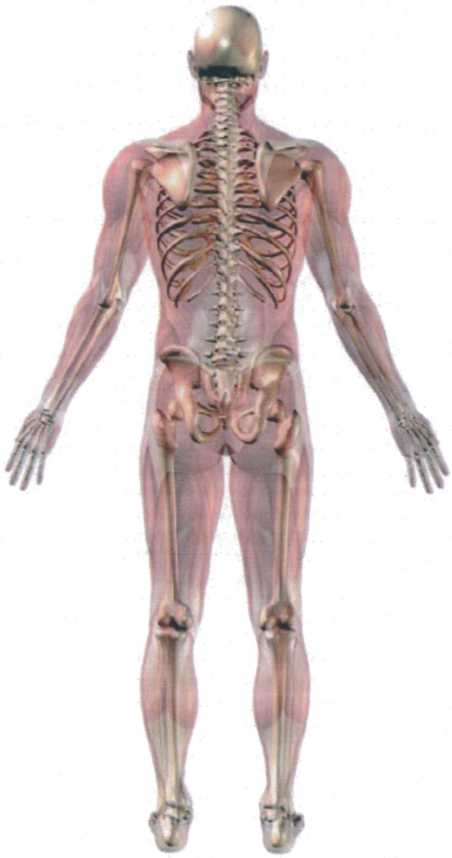
ANATOMY FORM

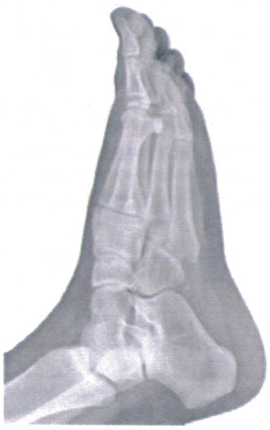
Instructions for Employee:

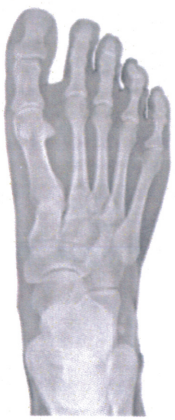
Please circle the injured body part(s) then sign and date this form.

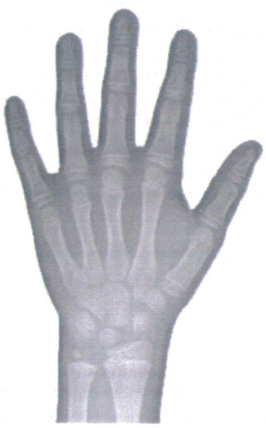
Signature of Claimant _____ Date _____

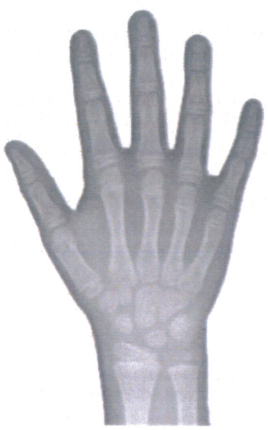












BELMONT COUNTY COMMISSIONER

SUPERVISOR'S REPORT

Employee Name _____

Nature of Injury (State employee's complaints and body part injured) _____

_____

How did the incident occur? _____

_____

In view of a camera? _____

Cause of the incident? _____

_____

Was the incident preventable? ☐ Yes ☐ No

If yes, explain _____

_____

_____

What actions have been taken to prevent a reoccurrence of incident? _____

_____

_____

Employee sent to _____

Did employee report back to work? ☐ Yes ☐ No

Does Employee have work restrictions? (List) _____

_____

Date returned to work: _____ In what capacity? ☐ Full Duty ☐ Light Duty

Employer's Address _____

Supervisor's Name: _____ Supervisor's Phone: _____

Signature of Supervisor: _____ Date: _____

BELMONT COUNTY COMMISSIONER

WITNESS STATEMENT

Name of injured worker: _____

Date of injury _____ Time of injury: _____(a.m. or p.m.)

Place of injury: _____

Description of injury: _____

Description of how injury occurred: _____

_____

Did you see the accident? ☐ Yes ☐ No

Describe how you became aware of the incident _____

_____

How did the injured person describe the accident to you? _____

_____

Who else was aware of the accident? _____

Was the injured employee on the clock or on duty when the incident occurred? _____

Describe any known previous injuries or problems this person has with the same part of the body:

_____

Any other information you wish to provide? _____

_____

Witness's Name _____ Witness's Address _____

Witness's Phone: _____

Signature of Witness: _____ Date: _____