

## 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 filling 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 received 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.

and that I will notify BWC immediately upon receiving any compensation or benefits from any source for this claim.							] '		(R.C. 2913.48)
	Last name, first name, mid	S	ocial Security nu		Marital status ☐ Single	Date of bir	th		
	Home mailing address				ex ] Male □ Femal		☐ Married ☐ Divorced	Number of dependents	
	City	Sta	ate 9-digit ZIP	code C	ountry if differe		☐ Separated ☐ Widowed	Departmen	nt name
	Wage rate \$	☐ Hour Per: ☐ Year	☐ Month ☐ Wee	- · · ·	Vhat days of the ☐Sun ☐Mon	•	•	TEri □ Cat	Regular work hours From To
Ö	Have you been offered or o	to you expect to receive a	payment or wages	for this claim	from anyone o	ther than the	Ohio Bureau		n or job title
h in	of Workers' Compensation? Yes No If yes, please explain.  Employer name								
injured worker and injury/disease/death info.	Mailing address (number and street, city or town, state, ZIP code and county)								
ease	Location, if different from mailing address								
/dis	Was the place of accident or exposure on employer's premises? ☐ Yes ☐ No (If no, give accident location, street address, city, state and ZIP code)								
njury		Time of injury	me of injury				Date last worked Date returned to work		
and i	Date hired	ate hired State where hired D				Oate employer notified State where supervised			
ker	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)		
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nred									
Ξ									
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 Pharma Family Services and the Ohio Rehabilitation Services Commission to release medical, psychological, psychiatric, pharmaceutical, vocational and social information. I understand this may include 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 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 BVC to 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 recommendation of the presentative for any and all such previous or future claims. The released claims information may include any recommendation of the presentatives of the released claims information may include any recommendation of the presentatives.								lude personally identifying information r in this claim, the employer's managed C to share claims information with the	
	Health-care provider name				Telephone number		Fax number		Initial treatment date
	Street address			( C	ity		( )	State	9-digit ZIP code
Ġ	Diagnosis(es): Include ICD code(s)								
eatment info.									
men									
Treat	Will the incident cause the miss eight or more days of E code	Is	s the injury caus		ne industrial incident?				
	Health-care provider signat	ure						'	
Ž	Employer policy number  Check if Employer is self-insuring Injured worker is owner/partner/member of firm								1
	Telephone number (	Telephone number Fax number E-mail address				Federal ID nu			
ę.	Was employee treated in a	Was employee hospitalized overnight as an inpatient? ☐ Yes ☐ No							
rer in	If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code								
Employer info.					he employer slidity of this claim for listed below:		For self-insuring employers only  Clarification - The employer clarifies and allows the claim for the condition(s) below:  Medical only  Lost time		
	Employer signature and title	е					Date		OSHA case number