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 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.

(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 ☐ Month ☐ Week ☐ Year ☐ Other _____ | 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

Mailing address (number and street, city or town, state, ZIP code and county)

Location, if different from mailing address

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)

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 injury/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: Austintown Urgent Care | Telephone number: (330) 884-1500 | Fax number: 330 884-1577 | Initial treatment date

Street address: 20 Ohltown Rd | City: Youngstown | State: OH | 9-digit ZIP code: 44515

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

E code | 11-digit BWC provider number: 12970 15-001 | Date

Health-care provider signature

Employer info.

Employer policy number | Check if ☐ Employer is self-insuring ☐ Injured worker is owner/partner/member of firm

Telephone number ( ) | Fax number ( ) | E-mail address | Federal ID number | 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, provide 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** ☐ **Lost time**

Employer signature and title | Date | OSHA case number

BWC-1101 (Rev. June 12, 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

Steward WorkMED

60 Marwood Circle, Suite B • Boardman, Ohio 44512 • (330) 884-2020 • Fax (330) 629-8733

PATIENT VISIT FORM

PART I: PERSONAL INFORMATION

LAST NAME FIRST MIDDLE INTIAL JR/SR/OTHER

SOCIAL SECURITY # _____ DATE OF BIRTH_____ HOME PHONE_____

ADDRESS_____STATE_____ZIP_____ WORK PHONE:_____

PART II: EMPLOYER INFORMATION

EMPLOYER NAME:_____ADDRESS_____

EMPLOYER PHONE#:_____CITY_____STATE:_____ZIP CODE_____ _____

MCO:_____CLAIM#_____

JOB TITLE:_____

PART III: WORKERS COMPENSATION HISTORY

DATE OF INJURY:_____INITIAL INJURY CARE GIVEN AT_____HOSPITAL/MEDICAL CENTER

PLEASE GIVE A BRIEF DESCRIPTION OF ACCIDENT OR ONSET OF ILLNESS: BODY PARTS INJURED/AFFECTED

_____

HAVE YOU EVER BEEN TREATED AT WORKMED FOR A PREVIOUS OR YOUR CURRENT INJURY? (IF YES, PLEASE EXPLAIN)

_____

HAVE YOU EVER FILED ANY OTHER WORKERS COMP CLAIMS OR RECEIVED BENEFITS, TREATMENT, OR REHAB FOR A WORK RELATED INJURY OR ILLNESS?_____

PAST MEDICAL HISTORY:_____

CURRENT LIST OF MEDICATIONS:_____

ALLERGIES TO:_____RATE YOUR CURRENT LEVEL OF PAIN 0 1 2 3 4 5 6 7 8 9 10

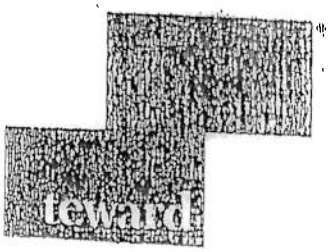
NO PAIN — WORST POSSIBLE PAIN

HAVE YOU RETURNED TO WORK? CIRCLE ONE YES - FULL DUTY YES – LIGHT DUTY NO

I understand that in order to facilitate my recovery from my work injury and ensure my safe and successful return to my regular job in a timely manner, I must attend all of my scheduled appointments, including WorkMED office visits, therapy, consultations, etc. I also understand that if I miss two or more appointments, that I may be discharged from WorkMED and that I may jeopardize my workers compensation claim

_____ _____

SIGNATURE DATE



World class health care where you liv

WorkMED 20 Ohltown Rd Austintown OH 44515 Ph: 330-841-1600
WorkMED 60 Marwood Circle Boardman OH 44512 Ph: 330-841-2020

DEAR PATIENT:

THERE ARE TIMES WHEN WE MAY NEED TO CONTACT YOU BY PHONE OR VOICEMAIL, IN THAT EVENT WE NEED YOUR PERMISSION TO CONTACT YOU OR A FAMILY MEMBER. PLEASE FILL OUT THE BOTTOM PORTION OF THIS FORM REGARDING THAT CALL.

I _____ GIVE MY PERMISSION/DO NOT GIVE MY PERMISSION TO WORKMED TO CALL PHONE # _____ AND LEAVE A MESSAGE WITH A FAMILY MEMBER OR LEAVE A VOICEMAIL REGARDING MY APPOINTMENT.

I _____ GIVE MY PERMISSION/DO NOT GIVE MY PERMISSION TO WORKMED TO SPEAK WITH _____ REGARDING MY CARE.

_____

SIGNATURE DATE

THANK YOU

WORKMED