NEW CLAIM CHECKLIST

FORM	DATE COMPLETED
Employee Incident Report: To be completed by the injured employee immediately.	
Authorization for Release of Medical Information: To be signed by the injured employee immediately.	
Employee Medical Absence Form: This form should be given to any injured employee seeking outside medical treatment. The form should be completed by the provider and returned to the Employer before injured employee returns to work.	
Supervisors Report of Incident: To be completed by the employee's supervisor after initial investigation.	
Witness Statement: To be completed by all individuals who were witnesses to the incident.	
Authorization of Representation of Employer (R-1 Pink Card): To be signed by the Employer and submitted to RB&S with every new claim application.	
BWC First Report of Injury (FROI-1): To be forwarded to RB&S and your MCO upon receipt.	
ALL OF THE ABOVE INFORMATION FORWARDED TO RB&S AND MCO.	

TO BE COMPLETED AND SIGNED BY THE EMPLOYEE AS SOON AFTER THE INCIDENT AS POSSIBLE

INCIDENT REPORT

Employee Name: _____ Employment Location: _____

Home Address: _____ Employee SS # _____/_____/_____

_____ Date of Birth: _____ Male/Female

Telephone No.: _____ Job Title/Occupation: _____

Shift: _____ Date of Hire: _____

Date of Incident: _____ Time of Incident: _____ am/pm

Location of Incident: _____

Are you reporting this accident as an industrial injury? ☐ Yes ☐ No

Describe your activities at the time of the incident. _____

_____

Describe how the injury occurred: _____

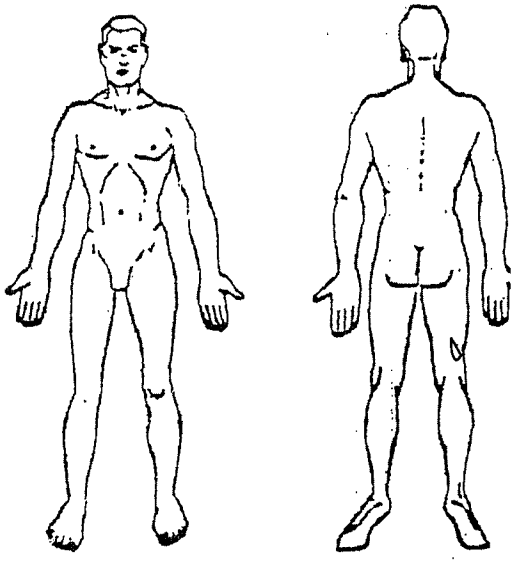
_____

Specifically list what parts of your body were involved and circle on the diagram.

_____

_____

_____



List the full name and title/position of all witnesses to the incident:

_____

Where were the witnesses located at the time of the incident? _____

_____

Did you immediately report the incident to your Employer? ☐ Yes ☐ No

If so, list first and last name and position _____

If not, why not? _____

Did you receive first aid treatment on site? ☐ Yes ☐ No From Whom? _____

What type of first aid did you receive? _____

Did you seek initial medical treatment from a hospital or doctor? ☐ Yes ☐ No

Date and time: _____

List name of hospital/doctor and city located: _____

Describe treatment: _____

Diagnosis/nature of injury/illness: _____

Were you released to return to your regular job? ☐ Yes ☐ No To light duty? ☐ Yes ☐ No

If light duty, list restrictions given: _____

Have you ever previously injured the body part(s) involved in the present injury? [ ] Yes [ ] No

When? _____

Was the previous injury work related? _____

List the name, city and phone number of all doctors and hospitals who treated you previously and what parts of your body they treated. _____

_____

MEDICAL RELEASE: I authorize my doctor, medical facility and/or insurance company to release any diagnosis, medical records, records of medical expenses paid or settlements relating to this injury or any other illness or injury to my employer, by and through Ross, Brittain and Schonberg Co., L.P.A.

_____ _____

Employee's Signature Date

Ohio | Bureau of Workers' Compensation

Authorization to Release Medical Information

Instructions

*You can obtain this form online at **ohiobwc.com***

- Please print or type.
- List the provider(s) you are authorizing to release medical records in the space indicated on this form.
- Please sign and date the form, and send it to the customer service office where your claim is located or to your self-insured employer.

Injured worker name (first, M.I., last)		Date of injury	Claim number
Address	City	State	Nine-digit ZIP code
Employer name	Employer MCO or QHP		

I, the above-named injured worker, understand I am allowing the Ohio Rehabilitation Services Commission and the providers (persons or facilities) named here (_____

_____) that attend or examine me to release the following medical, psychological and/or psychiatric information (excluding psychotherapy notes) that are related causally or historically to physical or mental injuries relevant to my workers' compensation claim:

- Pathology slides and immunohistochemical staining results, if applicable;
- Hospital admission history and physical; emergency room reports; hospital discharge summaries; physician office notes; physical therapist, occupational therapist or athletic trainer assessments and progress notes; consultation reports; lab results; medical reports; surgical reports; diagnostic reports; procedure reports; nursing home and skilled nursing facilities documentation; home nursing progress notes; or other listed below.

_____.

I understand I am authorizing the release of this information to the following: the Ohio Bureau of Workers' Compensation (BWC), the Industrial Commission of Ohio, the above-named employer, the employer's managed care organization or qualified health plan and any authorized representatives.

I understand this information is being released to the above-referenced persons and/or entities for use in administering my workers' compensation claim.

This authorization to release medical, psychological and/or psychiatric information shall remain in effect for as long as my workers' compensation claim remains open under Ohio law. I understand I have the right to revoke this authorization at any time. However, I must submit my revocation in writing and file it with BWC or my self-insured employer. My decision to revoke this authorization will be effective, except in the case that any provider referenced above already has relied on my authorization and released information.

I understand the provider(s) referenced above may not make my completing and signing this authorization a condition of my treatment.

I understand the parties I am authorizing the release of information to are exempted from the federal privacy requirements of the Health Insurance Portability and Accountability Act of 1996 as they administer workers' compensation programs. Information disclosed pursuant to this authorization may be redisclosed by them and may no longer be protected by the federal privacy requirements. I understand such redisclosures may include but are not limited to the following:

- A copy of the medical information the employer receives may be forwarded to BWC by the employer;
- A copy of the medical information will be available to me or my physician of record upon request to BWC or to the employer.

Injured worker (or guardian or personal representative) signature	Date

If signed by the injured worker's guardian or personal representative, provide a description of the guardian or personal representative's authority to sign on behalf of the injured worker. _____

_____.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____ (SS# _____, DOB _____) hereby grant my Employer, _____ , by and through Ross, Brittain, & Schonberg Co., L.P.A., the right to review, inspect and copy any and all reports and records, both medical and hospital, charts, x-rays and x-ray reports, with regard to my condition, whether it be physical or mental, and the treatment for same. Additional information covered under this release includes any and all workers' compensation claims and documents related thereto.

This authorization shall be in effect until further notice and upon my request at any time, may be withdrawn through written notification to my Employer through its legal counsel. I also agree that a xerox copy of this authorization may be used in place of the original.

_____

Ohio | Bureau of Workers' Compensation

Physician's Report of Work Ability

Injured worker name			Claim number
Date of injury	Date of last appointment/examination	Date of this appointment/examination	Date of next appointment/examination

MEDCO-14 submission (Select one of the options below.)

1
- ☐ I have never completed a MEDCO-14. ***Proceed to section 2.***
- ☐ I have previously completed a MEDCO-14, and all of the information remains the same. ***Proceed to and complete section 8.***
- ☐ I have previously completed a MEDCO-14, and I am providing updates appropriately checking Yes or No on each section.

Employment/Occupation (Complete this section and proceed to section 3.) (Updates Yes ☐ No ☐)

2 Have you reviewed the description of the injured worker's job held on the date of injury (former position of employment)? Yes ☐ No ☐
If yes - please indicate who (select all sources) provided the job description ☐ Injured worker ☐ Employer ☐ MCO ☐ BWC

Work status/Injured worker's capabilities (Updates Yes ☐ No ☐)

3A Does the injured worker have any physical or health restrictions related to allowed conditions in the claim? Yes ☐ No ☐
If yes, are the restrictions: ☐ Permanent ☐ Temporary ***Proceed to section 3B.***
If no, please check the box to indicate the injured worker is released to work as of the date of this exam. ☐ ***Proceed to section 8.***

3B If there are restrictions, can the injured worker return to the full duties of his/her job held on the date of injury (former position of employment)? Yes ☐ No ☐
If yes, please check the box to indicate that the injured worker is released to work as of the date of this exam. ☐ ***Proceed to section 8.***
If no, please indicate when the injured worker could not do the job held on the date of injury for this period of restricted duty.
Date:____/____/____.
Please estimate when the injured worker should be able to return to the job held on the date of injury for this period of restricted duty.
Date:____/____/____. **Proceed to section 3C.**

3C **Please indicate which of the activities listed below the injured worker can perform (even if the response to 3B is No.)**
If the injured worker is not released to the former position of employment but may return to available and appropriate work with restrictions, please indicate the possible return to work date: ____/____/____.
The injured worker can perform simple grasping with: ☐ Left hand ☐ Right hand ☐ Both
The injured worker can perform repetitive wrist motion with: ☐ Left hand ☐ Right hand ☐ Both
The injured worker's dominant hand is: ☐ Left ☐ Right
The injured worker can perform repetitive actions to operate foot controls or motor vehicles with: ☐ Left foot ☐ Right foot ☐ Both
If the injured worker is taking prescribed medications for the allowed conditions in this claim, can the injured worker safely:
*Operate heavy machinery: ☐ Yes ☐ No *Drive: ☐ Yes ☐ No **Perform other critical job tasks as defined by any source listed above in section 2:* ☐ Yes ☐ No

Please indicate the following: N = Never, O = Occasionally, F = Frequently, C = Continuously										Lifting/carrying					Pushing/pulling				
Activity	N	O	F	C	Activity	N	O	F	C	0 - 10 lbs.					0 to 25 lbs.				
Bend					Reach above shoulder					11 - 20 lbs.					26 to 40 lbs.				
Squat/kneel					Type/keyboard					21 - 40 lbs.					41 to 60 lbs.				
Twist/turn					Work with cold substances					41 - 60 lbs.					61 to 100 lbs.				
Climb					Work with hot substances					61 - 100 lbs.					100 + lbs.				

How many total hours can the injured worker work: _____ per week _____ per day?
In an eight-hour workday, how many total hours can the injured worker: Sit: ____ hours ☐ Continuously ☐ With break
Walk: ____ hours ☐ Continuously ☐ With break Stand: ____ hours ☐ Continuously ☐ With break
Does the injured worker have any functional restrictions based only on allowed psychological conditions? ☐ Yes ☐ No If Yes, please describe in space provided below. Note: If Yes is indicated please reference the MEDCO-16 as needed.
Additionally, in this space, please provide any additional information addressing the injured worker's capabilities and/or job accommodations which may not be addressed above. _____

Proceed to section 4.

Injured worker name	Claim number	Date of injury

Disability information (If 3B above is "NO" or dates updated - all 4A fields, including site/location if applicable must be completed) (Updates Yes ☐ No ☐)

4A Complete the chart below and furnish the narrative description of the diagnosis(es), site/location, if applicable, and International Classification of Diseases (ICD) code(s) for the condition(s) being treated due to the work-related injury/disease. Please indicate if the condition is preventing the injured worker from returning to job duties he/she held on the date of injury.

Narrative description of the work-related allowed condition	Site/location if applicable	ICD code	Is the condition preventing full duty release to the job injured worker held on the date of injury?
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐

4B List all other relevant conditions that impact treatment of the conditions listed above (e.g., co-morbidities or not yet allowed conditions).

Clinical findings: You can reference office notes in lieu of writing clinical findings below. (Updates Yes ☐ No ☐)

5 The injured worker is progressing: ☐ As expected ☐ Better than expected ☐ Slower than expected
Provide your clinical and objective findings supporting your medical opinion outlined on this form. List barriers to return to work and reason, for the injured worker's delay in recovery.

Maximum medical improvement (MMI) (Updates Yes ☐ No ☐)

6 MMI is a treatment plateau (static or well-stabilized) at which no fundamental functional or physiological change can be expected within reasonable medical probability, in spite of continuing medical or rehabilitative procedures. Has the work-related injury(s) or occupational disease reached MMI based on the definition above? Yes ☐ No ☐
If yes, give MMI date: _____/_____/_____. If no, please provide the proposed treatment plan, including estimated duration of each treatment (attach additional sheet if necessary).

Note: An injured worker may need supportive treatment to maintain his or her level of function after reaching MMI. Thus, periodic medical treatment may still be requested and provided.

Vocational rehabilitation (Updates Yes ☐ No ☐)

7 Vocational rehabilitation is an individualized and voluntary program for an eligible injured worker who needs assistance in safely returning to work or in retaining employment. This program can be tailored around an injured worker's restrictions and may provide job seeking skills or necessary retraining. Is the injured worker a candidate for vocational rehabilitation services focusing on return to work?
Yes ☐ No ☐ If no, please explain why and provide your recommendations to help the injured worker return to employment.

Treating physician signature - mandatory

8 I certify the information on this form 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 be punished, under appropriate criminal provisions, by a fine or imprisonment or both.

Treating physician's name (please print legibly)		Address, city, state, nine-digit ZIP code	
Treating physician's signature			
BWC provider (Peach) number	Date	Telephone number	Fax number

Medical Absence Form

Time In _____ Time Out _____

Patient Name _____ Date of Injury _____

Company Name _____ Date of Exam _____

Diagnosis _____

or Notes _____

RETURN TO WORK STATUS

____ **May Return to work without restrictions.** ____ May not return to work until _____

____ May return to work with the following restrictions or recommendations:

____ Patient referred for Physical Therapy ____ No ____ Yes, to: _____

	% of Time Spent in Normal Work Shift						% of Time Spent in Normal Work Shift				
TASK OR PROCESS	CONT 60+%	FREQ 30-60%	OCC <30%	NONE 0%	NA	TASK OR PROCESS	CONT 60+%	FREQ 30-60%	OCC <30%	NONE 0%	NA
Lift or Carry						**Vibrating Tools**					
more than 50 lbs						Right Hand					
up to 50 lbs						Left Hand					
up to 40 lbs						Both Hands					
up to 30 lbs						**Grip or Grasp**					
up to 20 lbs						Right Hand					
up to 10 lbs						Left Hand					
up to 5 lbs						Both Hands					
						Fine Manipulation					
Push or Pull						Right Hand					
more than 50 lbs						Left Hand					
up to 50 lbs						Both Hands					
up to 40 lbs						**Work Above Shoulder**					
up to 30 lbs											
up to 20 lbs						**Reach Forward**					
up to 10 lbs						**Work Below Waist**					
up to 5 lbs											
						Work with Gloves					
Walk						**Climb Ladders**					
Stand						**Climb Stairs**					
Bend						**Use Foot Operated Machinery**					
Stoop											
Kneel						Right Foot					
Crawl						Left Foot					
Sit						Both Feet					
						Drive Lift Truck/ Tow Motor					

CONTINUOUSLY / FREQUENTLY / OCCASIONALLY / NONE

_____ Other _____ Restricted until _____

Next Clinic Appt. _____

Notes _____

_____

_____

_____

Physician's Signature

TO BE COMPLETED IMMEDIATELY AFTER INJURY REPORTED/KNOWN BY THE INJURED EMPLOYEE'S SUPERVISOR

SUPERVISOR'S REPORT OF INCIDENT

(Review the employee's incident report)

Employee's Name: _____ Date of Incident: _____

Supervisor's Name: _____ Time: _____

Did you see the incident occur? __ yes ___ no If so, please describe what occurred: _____

_____

_____

Did the employee report injury himself/herself? __ yes ___ no

If no, by whom? _____

When was it reported? _____

Was incident reported as he/she states in his/her injury report?_____

If not, what are differences? _____

_____

Do you know from personal knowledge whether incident occurred as stated by the employee? ___ Yes ___ No

Who are the witnesses? _____

What did the witnesses say to you about the incident? _____

_____

_____

List all individuals (other than witnesses already listed) that you interviewed regarding the incident?

_____

Describe information provided, if pertinent: _____

_____

What was the employee's apparent physical condition and appearance when the incident occurred or was reported to you?_____

What physical complaints, if any, did employee make?

_____

_____

Describe any first aid provided by you or others: _____

_____

_____

Did the employee need to go for additional medical assistance?_____

If so, where was employee sent? _____

Did he/she come right back to work after treatment? _____

Did he/she work the next day? ___ Yes ___ No Regular or light duty? _____

Describe the light duty work? _____

If employee did not return to work, when is employee expected back to work? _____

Are you personally aware of, or has this employee ever mentioned, prior industrial or non-industrial injuries, illnesses, problems or hobbies to you or to others that may have a bearing on this injury? Please describe:

_____

_____

_____ _____

Supervisor's Signature Date

TO BE COMPLETED BY ALL PERSONS LISTED ON EMPLOYEE AND SUPERVISOR REPORTS AS WITNESSES

WITNESS STATEMENT

Name: _____

Were you a witness to an incident involving _____
(employee injured)
on _____? ☐ Yes ☐ No
(date of incident)

Describe location of incident and approximate time.

_____

_____

Where were you in proximity to incident? (In front, back, etc; number of feet, etc.):

_____

Describe exactly what you saw: _____

_____

_____

Did _____ appear injured? ☐ Yes ☐ No
(employee injured)

If so, please describe the body part that was involved, what the injury was, and the apparent cause, if you could tell:

_____

_____

_____

Did you speak to _____ at or near the time of the incident? ☐ Yes ☐ No
(employee injured)

If so, what did he/she tell you? _____

_____

_____

Did you offer any assistance? ☐ Yes ☐ No

If so, please describe: _____

_____

Have you had any subsequent discussions with _____ regarding the incident? ☐ Yes ☐ No
(employee injured)

If so, when? _____

What did he/she tell you on this occasion? _____

_____

_____

_____

Please add any additional comments you may have regarding this incident:

_____

_____

_____

_____

_____ _____

Witness Signature Date

Employer Authorized Representative

INSTRUCTIONS:

- The employer and representative must complete this form and file it with BWC.
- You must possess a valid BWC Representaitve ID number.
- To obtain a valid Representative ID number, contact the Central Office, customer assistance desk at 614.466.1958 or 614.466.1563, or inquire at any BWC customer service office information desk.

Injured worker name	Claim number
Date of injury	Employer policy number
Employer name	
Employer address	City, State, Zip Code

REPRESENTATIVE

Representative name **Ross, Brittain & Schonberg Co., LPA**	Representative I.D. number **21668-91**
Address **6480 Rockside Woods Blvd. South – Suite 350**	Telephone number **216-447-1551**
City, State, Zip Code **Cleveland, OH 44131**	
Representative email address	Fax number **216-447-1554**

AUTHORIZATION

I hereby authorize the above representative to represent me in the above claim before the Ohio Bureau of Workers' Compensation and the Industrial Commission of Ohio. This authorization also entitles this Representative to automatically receive correspondence generated in the above claim file.

X	
Signature of employer official granting this authorization	**Date of Authorization**

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 the Ohio 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, and the Ohio Rehabilitation Services Commission (where relevant) to release medical, psychological, psychiatric, vocational or social 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 BWC 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 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	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

Tear off this sheet and return the completed form to your employer's managed care organization (MCO) or to your local BWC customer service office.