

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 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Date of birth		
Home mailing address				Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Number of dependents			
City		State	9-digit ZIP code		Country if different from USA		Department name		
Wage rate \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Month <input type="checkbox"/> Week <input type="checkbox"/> Year <input type="checkbox"/> Other _____			What days of the week do you usually work? <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thur <input type="checkbox"/> Fri <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, give accident location, street address, city, state and ZIP code)									
Date of injury/disease		Time of injury _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		If fatal, give date of death		Time employee began work _____ <input type="checkbox"/> a.m. <input type="checkbox"/> 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)			
<i>Benefit application/medical release - I am applying for a claim under the Ohio Workers' Compensation Act for work-related injuries that I did not purposely 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 causally 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 MCO and any authorized representatives.</i>									
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? <input type="checkbox"/> Yes <input type="checkbox"/> No				Is the injury causally related to the industrial incident? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Health-care provider signature				11-digit BWC provider number			Date	

Employer info.

Employer policy number			<input type="checkbox"/> Employer is self-insuring <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			Was employee hospitalized overnight as an inpatient? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code						
<input type="checkbox"/> Certification - The employer certifies that the facts in this application are correct and valid.		<input type="checkbox"/> Rejection - The employer rejects the validity of this claim for the reason(s) listed below:		For self-insuring employers only <input type="checkbox"/> Clarification - The employer clarifies and allows the claim for the condition(s) below: <input type="checkbox"/> Medical only <input type="checkbox"/> Lost time		
Employer signature and title				Date	OSHA case number	

PATIENT HISTORY FORM

(If seen within one year, please list changes)

Date:	
D.O.B	
S.S.#	
Age	
Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>
Marital Status	S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/>

NAME (print)

Referred here by: (circle one) self family friend doctor attorney
other health professional

Name of Person/Physician making referral:

Primary Care Physician/Family Doctor:

Please describe the reason for your visit: Body Part right left both
Acute Injury - new (circle one) yes no Chronic Symptoms - old (circle one) yes no

How did your symptoms begin? If sudden, describe onset:

On scale of 1-10 (10 being most severe) circle # that best describes your pain 1 2 3 4 5 6 7 8 9 10

Approximate date symptoms began or date of injury:

Resulting from: (circle which applies) Sports Accident Work Related Involving litigation

Are symptoms constant intermittent worsening improving

Check all that apply pain stiffness swelling instability weakness numbness/tingling

What makes symptoms worse?

What makes symptoms better?

What previous or formal treatment have you had? (medications, therapy, surgery, injections)

Were previous treatments helpful to any degree? If so what?

PAST SURGICAL HISTORY AND/OR HOSPITALIZATION

Previous: Type of Operations or reason for Hospitalization	Year
1	
2	
3	
4	

Any previous fractures? yes no

Any other serious injuries? yes no

MEDICATION INFORMATION

Drug Allergies: Do you have any drug allergies? (circle one) yes no Allergic to Latex? (circle one) yes no

If yes name the drug and the type of reaction. (example rash, nausea, etc) PLEASE BE SPECIFIC.

Current Meds: (List any medications you are taking at this time. Includes such items as aspirin, vitamins, laxatives, calcium, etc.)

Name of Drug	Dose (include strength and number of pills per day)	How long have you taken this medication?	Please Check: Helped?		
			A lot	Some	Not At All
1					
2					
3					
4					
5					
6					

PLEASE TURN OVER AND COMPLETE MEDICAL HISTORY

MEDICAL HISTORY/REVIEW OF SYSTEMS

Please check if you have had a history of any of the following:		YES	NO		YES	NO
GENERAL				CARDIOVASCULAR		
Are you currently pregnant?				Chest pain, Angina		
Diabetes				Heart Attack, Myocardial Infarction		
Stroke				Palpitations		
Kidney Disease				High Blood Pressure, Hypertension		
Ulcers				Shortness of Breath		
Asthma or Lung Disease				Ankle Swelling		
Cancer TYPE:				HEMATOLOGIC		
Fatigue				Anemia		
Weakness				Blood clots		
Fevers				Bleeding tendency		
Skin Problems/disorders TYPE:				Easily bruised		
Rheumatic Fever				Circulatory problems		
Tuberculosis				Blood thinners (currently on)		
Recent weight loss/gain. How Much?				(if yes, type?)		
BLOODBORNE PATHOGENS				Phlebitis		
HIV/AIDS				MUSCULOSKELETAL		
Hepatitis				Joint Pain		
Other				Joint Swelling		
SITES OF INFECTION				Muscle weakness		
Urinary				Muscle tenderness		
Dental				Morning Stiffness		
Other				Arthritis/Osteoarthritis		
NEUROLOGICAL				Rheumatoid Arthritis		
Headaches				Bunions		
Dizziness				Osteoporosis		
Fainting				Previous bone density test?		
Memory Loss				Bone/Joint infections		
Loss of consciousness				Gout		
Muscle spasms				PSYCHOLOGICAL		
Numbness or tingling of hands/feet				Depression		
Blindness or trouble seeing				Anxiety disorder		
Deafness or trouble hearing				Other		
Seizures						

Other illnesses or diseases which are not listed? Please describe

FAMILY HISTORY

Please check if any of your family (parents, brothers, sisters, grandparents) have a history of any of the following:

		YES	NO		YES	NO
Diabetes (sugar)				Abnormal bleeding tendencies		
Heart Disease				Rheumatoid Arthritis		
Anesthetic complications				Osteoarthritis		
Cancer TYPE:				Gout		

SOCIAL HISTORY

What is your approximate weight? Lbs. Height? Ft. In. Shoe size BMI (doctor use)

Occupation No. of years Job Duties

Do you smoke? (circle one) yes no past If yes or past, # of packs per day, # of years

Are you (circle one) right handed left handed

Do you consume alcohol? If so how many drinks per week? Is there history of abuse? (circle one) yes no

Have you ever had a problem with drugs? (circle one) yes no

Do you participate in recreational drugs? (circle one) yes no past If yes or past, list type and amount.

Do you regularly wear your seat belt? (circle one) yes no

Please list all sports and hobbies you are involved in:

What is your principle support system? Example Spouse, Family, Friends, Church

I, as the patient, state the information is correct and accurate to the best of my knowledge.

(patient signature) Date:

I have reviewed this information with this patient.

(M.D. signature) Date: