



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.

Form section for injured worker and injury/disease/death info. Includes fields for last name, first name, middle initial, Social Security number, marital status, date of birth, home mailing address, sex, number of dependents, city, state, 9-digit ZIP code, country, department name, wage rate, work days, regular work hours, occupation or job title, employer name, mailing address, location, accident details, and signature.

Treatment info.

Form section for treatment info. Includes fields for health-care provider name, telephone number, fax number, initial treatment date, street address, city, state, 9-digit ZIP code, diagnosis(es), and incident details.

Employer info.

Form section for employer info. Includes fields for employer policy number, telephone number, fax number, e-mail address, federal ID number, manual number, treatment location, and certification/rejection/clarification options.

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.