Worker's Compensation Instructions

Please completely fill out each of the three attached forms regardless of severity of injury.

Injury Report –

✓ Employee is to complete top half (please give detail, make sure your first and last name is on form and is legible).

✓ Supervisor completes bottom half (please make sure your name is legible).

First Report of Injury Report –

✓ Employee is to complete top half of report (if you seek medical attention the middle sections is for medical provider to complete and the bottom is for HR).

Medical Release Form –

✓ Employee, please also complete this form even if you do not seek medical attention at the time.

Seeking Medical Attention –

✓ You have the option of going to the ER, MedWorks (937) 449-0800, or you may choose your own physician but before you incur costs make sure your physician treats Worker’s Compensation patients.

Return all three completed forms to Human Resources as soon as possible. If you have any questions, please do not hesitate to contact us at 937-229-2541.
UNIVERSITY OF DAYTON

WORK RELATED ACCIDENT/ILLNESS/INJURY REPORT

NOTE: This form must be completed and submitted to the Office of Human Resources within 24 hours of the date of occurrence. ***PLEASE PRINT***

TO BE COMPLETED BY EMPLOYEE:

1) Name: ________________________________

2) Job Title: ________________________________

3) Occurrence Date: ____________ Time of Occurrence: ____________ Location of Injury: ____________


5) Name of all Witnesses: __________________________________________

6) Complete description of occurrence (use back of sheet is necessary): ______________________________________________________________________________________________________

7) Degree of Treatment:

□ No Treatment Required □ First Aid Only / Required * □ Medical Treatment Refused

8) a) Treatment Provided by: ________________________________

b) Family Physician: ________________________________

9) Are Additional Treatments Necessary: ______________________________________________________________________________________________________

__________________________ __________________________
Print - Employee Name Employee Signature

TO BE COMPLETED BY SUPERVISOR

10) Reported to You:

Time: ____________ Date: ____________ By Whom: ____________ Did You Witness: ____________

11) What Did Employee Tell You Occurred: ______________________________________________________________________________________________________

12) Your Analysis of Occurrence: (Why)

__________________________________________________________________________________________

13) Based upon (11), what action can be/has been taken to prevent recurrence: ______________________________________________________________________________________________________

__________________________ __________________________
Print - Supervisor Name Supervisor Signature
First Report of an Injury, Occupational Disease or Death

By signing this form, I:

- Certify to only receive compensation and/or benefits that are provided for in this claim under Ohio workers' compensation laws;
- Waive and relinquish any 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, 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; and
- 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-insured employers by knowingly misrepresenting or concealing facts, making false statements or accepting compensation in lieu of which he or she is not entitled, is subject to felony criminal prosecution for fraud.

(R.C. 413, 48)

[Form fields for personal information, injury details, employer details, etc.]

BWC 1101 (Rev. 12/21/2011)
FROI-1 (Combines C-1, C-2, C-3, C-5, OD-1, OD-1-22)

This form meets OSHA 201 requirements.
Authorization to Release Medical Information

You can obtain this form online at ohiobwc.com

Instructions
- 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.

<table>
<thead>
<tr>
<th>Injured worker name (first, M.I., last)</th>
<th>Date of Injury</th>
<th>Claim number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City</td>
<td>State</td>
</tr>
</tbody>
</table>

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. __________________________________________

BWC-1224 (Rev. 1/14/2011)

C-101