**Part I Injury Report** *(to be completed as soon as possible following an accident and must be provided to the department supervisor within 24 hours of the accident.)(Email a copy to Timothy Werdmann within 48 hrs)*

Employee Name  Date of Incident  Time of Incident 

Time employee began work  Place of incident (Exact Work Site) 

Work Dept./Div  Date Hired  Date of Birth  Age  Sex (M/F)  Employee Social Security Number  Job Classification 

Employee Home Address  City  State  Zip 

Person Completing Form  Date Reported To Supervisor 

Was Incident Reported Immediately?  To Whom 

If no, explain 

Detailed description of the accident (Sequence of events directly supporting or caused the incident) Continue on page 2 if needed

**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.

Employee's Signature  Date Signed 

**Nature of Injury** (Parts of Body Affected) Re-injury of existing condition?  

Body Part    

    

   

Type of Incident   

   

   

  

   

Type of Injury    

    

    

    

 

**Part II Incident Confirmation** (to be completed by supervisor)

Where was treatment given?   

Worksite first aid provided by 

Describe worksite first aid treatment 

Medical Provider's name if treated off-site 

Describe off-site treatment (Please attach care provider notes and send with the report) 

Medical Provider's Address 

Was employee treated in an emergency room?  

Was employee hospitalized overnight as an in-patient?  

How was the incident verified? If possible, please attach statements.

  Name of Witnesses 

Can employee be reassigned to restricted duty?  If yes, date of first day of restricted duty 

Will the injury result in Lost Workdays?   If yes, date of first day of lost work 

Supervisor Signature  Date Signed 

Additional description of the accident (Sequence of events that directly supported or caused the incident)

**Part III Employer Information**

Employer Policy Number: 30905102-0 Employer Federal ID Number: 31-6000 142 Manual Number: 9431