

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

Today's Date: _____

1) Name: _____

Department: _____

2) Job Title: _____

Work Phone: _____

3) Occurrence Date: _____ Time of Occurrence: _____ Location: _____

4) Hours and Days You Work: _____

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: _____

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: _____

Supervisor Signature



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.



Better Workers' Compensation

Built with you in mind



First Report of an Injury, Occupational Disease or Death

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			
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 recognition of my claim under the Ohio Workers' Compensation Act for work-related injuries that I did not purposely inflict. I request payment for compensation and/or medical expenses as allowable. Direct payment(s) to the providers of any medical services are authorized. I understand that I am allowing any provider who attends to, treats or examines me to release all medical, psychological and/or psychiatric information that is causally or historically related to physical or mental injuries relevant to issues necessary to the administration of my workers' compensation claim to the Ohio Bureau of Workers' Compensation, the Industrial Commission of Ohio, the employer listed in this claim, that employer's managed care organization and any authorized representatives. I further authorize the Ohio Rehabilitation Services Commission to release information about my physical, mental, vocational and social conditions that is causally or historically related to physical or mental injuries relevant to issues necessary for the administration of my workers' compensation claim to the aforementioned parties.</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			Check if <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



**AUTHORIZATION FOR RELEASE
OF MEDICAL INFORMATION**

**INDUSTIAL COMMISSION OF OHIO
BUREAU OF WORKER'S COMPENSATION**

Claimant's Name _____
Social Security Number _____
Employer's Name University of Dayton _____
Date of Injury _____
Type of Injury/Illness _____

As provided by Section 4123.651(C) of the Ohio Revised Code, I hereby permit the release of medical information, records and reports relative to the issues necessary for the administration of my workers' compensation claim to the industrial Commission of Ohio, Ohio Bureau of Workers' Compensation, or the employer as such medical information, records and reports pertain to a condition either allowed or requested in my claim, or to consider the payment or to determine the eligibility of payment of compensation and medical benefits under my workers' compensation claim.

Signature of Claimant

Date