Injury / Illness Report

Employee Statement *(completed by employee)*

Check all that apply:

____ Full time Employee
____ Part-time Employee
____ Interim Employee
____ Exempt
____ Seasonal / temp
____ Other: _____

____ OCSEA
Unit _____
____ FOP Unit 2
____ 1199
____ ORC 124.381
____ ORC 124.15
____ OSTA
____ Other: _____

PERSONAL INFORMATION

Employee's full name:

Address (Street / City / State / Zip):

Social Security #:

Phone # (Home / Work):

Date of Birth:

Age:

Sex:

Your employer's name:

Job Title/Department:

Employer's BWC Policy #:

Regular work hours: From _____ am/pm To _____ am/pm

Work Days: ___Sun ___Mon ___Tues ___Weds ___Thurs ___Fri ___Sat

INCIDENT REPORT INFORMATION

Date/Time of Injury:

Were you working overtime when this injury occurred? ____ Yes ____ No

Reported to (Name/Title):

Date/Time Reported:

OFF WORK BENEFITS:

Check one benefit type:

____ Temporary Total Compensation
____ Salary Continuation*
____ Occupational Injury Leave* (see instructions page)

***Must seek medical treatment from WILMAPC approved provider** http://www.das.ohio.gov/wilmapc

Exact location of incident (Include name of building/area and location within building/area or town, county, State Route or mile marker):

Were there any witnesses? Please list names:

Are you working, in any capacity, for another employer: ____Yes ____ No If yes, employer name:

EMPLOYEE INCIDENT DESCRIPTION (Please DESCRIBE how the injury happened in DETAIL)

What duties were you performing?

What caused the injury? (e.g. I slipped on the ice.)

Indicate body part(s) affected (for example: left knee sprain):

Benefit application release of information / 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 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, Ohio Job and Family Services, and Opportunities for Ohioans w/Disabilities to release medical, psychological, psychiatric, pharmaceutical, vocational and social information. I understand this may include personally identifying 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, DAS, employing agency, the employer's BWC MCO and their 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 employer of record (or its 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. I have read and understand the information described on the ADM4303 instructions page. A photocopy of this authorization shall be as valid as the original.

Employee Signature:

Date:

PHYSICIAN'S STATEMENT (Take to your health-care provider to complete)

Health-care provider name (please print):

Initial treatment date:

Telephone number: ( ) -

Fax number: ( ) -

Street address, city, State, 9-digit ZIP code:

Diagnosis(es): Include ICD code(s):

Will the incident cause the worker to miss 8 or more days from work?
____Yes ____ No

Is the injury causally related to the industrial incident?
____Yes ____ No

E code:

11-digit BWC provider #:

Health-care provider signature and date: