Employee Instructions for completing the ADM 4303 Injury / Illness Report

This form **must be completed** as part of the workers' compensation application process. Failure to fully complete this report may result in the denial or delay of benefits. Write legibly with a black or blue ink pen (do not use pencil) or file electronically.

Employee Statement
The injured employee is responsible for completing the following sections:

Personal Information- Please fully complete all requested information.

Incident report Information
You must notify your supervisor immediately (within 24 hours) after any accident or onset of illness.

- Follow your specific agency's accident procedures
- Provide the exact date and time the accident occurred
- Provide the exact date and time the incident was reported
- List to whom (name, title and phone #) you reported the incident

Off Work Benefits – you must make a selection, refer to your specific bargaining unit contract for details. *You **cannot** collect temporary total compensation, salary continuation or OIL benefits during the same period of time.*

- ***Temporary Total Compensation (TT)*** – TT benefits are paid by the Bureau of Workers' Compensation (BWC). Your injury must result in eight (8) or more calendar days of lost time from work before TT is considered. Please refer to www.ohiobwc.com for specific details

- *** ***Salary Continuation (SC)*** – SC is equal to the employee's total rate of pay not to exceed 480 hours per workers' compensation claim and paid by the employer.

- *** ***Occupational Injury Leave (OIL)*** – An employee who incurs a work-related injury or illness inflicted by a ward of the State may be entitled to OIL. OIL is equal to the employee's total rate of pay not to exceed 960 hours per workers' compensation claim and paid by the employer. Refer to your specific bargaining unit contract for details, as OIL applies to certain agencies.

WILMAPC PROVIDER

*** **IN ORDER TO QUALIFY FOR SALARY CONTINUATION OR OCCUPATIONAL INJURY LEAVE, YOU MUST SEEK MEDICAL TREATMENT WITHIN 7 DAYS OF THE DATE OF INJURY FROM A PHYSICIAN ON THE WILMAPC APPROVED PHYSICIAN LIST.**

YOU MAY ACCESS THE WILMAPC PROVIDER LIST OR CONTACT YOUR MCO REPRESENTATIVE

http://www.das.ohio.gov/wilmapc

Employee Accident Description
You must explain in DETAIL how you were injured, including

- What caused the injury/illness, where the accident occurred, how the accident occurred, explain what you were doing at the time of the accident, include the ACTUAL SPECIFIC location where the incident occurred and list any witnesses to the incident

Nature of Injury/Illness
Indicate the body part affected and the illness or injury that resulted from the incident. Include details of any medical attention sought or plan to seek.

- Did you seek on-site medical treatment? Check yes or no. If yes, provide details of treatment rendered in "nature of Injury/Illness" section.
- Be sure to indicate name medical provider

Injured Worker Signature/Date
Please read and complete this form in its entirety. Be sure to date and sign it before returning it to your employing agency designee/personnel officer.

NOTICE: "The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information", as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."

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 name:

Address (Street / City / State / Zip):

Social Security #:

Phone # (Home / Work):

Date of Birth:

Age:

Sex:

Your employer's name:
SUPREME COURT OF OHIO

Job Title:

Employer's BWC Policy #:
10003101-0

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*; inflicted by a ward of the State (inmate, patient, resident, client, youth or student)

***Must seek medical treatment from 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 ACCIDENT 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.)

NATURE OF ILLNESS/INJURY (PLEASE BE VERY SPECIFIC)

Indicate body part(s) affected:

Describe the illness or injury resulting from the incident:

On-site medical treatment sought/rendered? ☐ Yes ☐ No If yes, from?

Clinician observation / assessment:

Clinician initials: _____

Outside medical treatment sought/rendered? ____Yes ____No (If yes, provide the **name and phone number** of medical provider below)

Physician's name & phone #:

Benefit application/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 the Ohio 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, and the Ohio Rehabilitation Services Commission (where relevant) to release medical, psychological, psychiatric, vocational or social 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. I understand that social security numbers are used to match individuals with other employment records that may be required in the processing of this claim and are used for informational purposes only. A photocopy of this authorization shall be as valid as the original.

Employee Signature	Date

Injury / Illness Report
Employer Statement *(completed by WC designee)*

Date received by personnel:

EMPLOYER INFORMATION

BWC Claim # and/or injury date:

Employee's Name:

Agency (Specify operating location or Central Office):

BWC Policy #:

Address (Street / City / State / Zip):

Work County:

Hire date:

Employment type: ☐ PT ☐ FT ☐ Interim ☐ Temp

Bargaining Unit Status: OCSEA Unit ☐ FOP ☐ 1199 ☐ Exempt ☐ Other: _____

Did employee seek nursing/first aid care? ☐ Yes ☐ No

If yes, from?

Was employee hospitalized overnight as in-patient? ☐ Yes ☐ No Or treated in the Emergency Room? ☐ Yes ☐ No

Was employee off work seven (7) consecutive days? ☐ Yes ☐ No

Did employee use sick leave, vacation leave, personal leave, or any other leave with pay for any of the lost work days? ☐ Yes ☐ No

If yes, have you attached a calendar of wages showing leave usage? ☐ Yes ☐ No

What was the last **date** the employee worked?

DATE _____

Has the employee returned to work? ☐ Yes ☐ No

If YES, give ACTUAL date:

If NO, give estimated RTW date:

Was a Transitional Work Assignment offered to this employee? ☐ Yes ☐ No

Is a Position Description and / or Job Analysis attached? ☐ Yes ☐ No

Did this injury result in a fatality? ☐ Yes ☐ No

If yes, give date of death:

Date faxed/called in to MCO:

By whom:

Employee has applied for payment under: ☐ Salary Continuation ☐ OIL ☐ BWC-TT ☐ Disability Other: _____

SC or OIL BENEFITS: *(Check if applicable) A completed calendar of wages must be submitted if SC or OIL is requested*

☐ **SALARY CONTINUATION**

☐ **OCCUPATIONAL INJURY LEAVE**

OIL - Do you believe this is a legitimate OIL injury? ☐ Yes ☐ No

Appointing Authority Signature: _____

Date:

Coordinator's initials:

Date employee became disabled:

Total hours being requested:

Treating with an approved WILMAPC physician? ☐ Yes ☐ No

Comments:

EMPLOYER CLAIM CONTACT **(please print clearly)**

Name	Title	Phone #

EMPLOYER CLAIM POSITION **(check applicable section)**

☐ CERTIFICATION

Based on the information known at this time the employer CERTIFIES that the facts in this application are correct and valid. This certification does not waive any appeal rights that may exist if the employer so chooses to exercise those rights.

☐ UNKNOWN

This claim is still in process and pending further investigation and claim research.

☐ REJECTION

The employer rejects the claim for the following reason(s):

Employer signature

Date

Injury / Illness Report

Supplemental Statement *(completed by Supervisor and Safety & Health Coordinator)*

Employee Name: _____

BWC Claim #: _____

Supervisor Statement *(to be completed by the Supervisor)*

Date Injury reported to supervisor:	Time Injury reported to supervisor:
Contributing weather or environmental factors:	Any equipment involved? ☐ Yes ☐ No If yes, please specify:

Was the employee performing his/her regular job duties? ☐ Yes ☐ No

If No, please explain:

Specific action taken to avoid another injury:

Will disciplinary action be initiated? ☐ Yes ☐ No

Please explain:

Supervisor full name:	Work phone #:	
Job title:	Regular shift:	Days off:
Supervisor's signature:		Date:

Safety & Health Statement *(to be completed by the S&H Coordinator)*

Fully describe the accident (What occurred, what was the injury type, what object directly harmed the employee?):

What was the employee doing immediately before the accident?:

What conclusions can be drawn?

Comments and/or recommendations to improve safety:

Is this incident PERRP recordable? ☐ Yes ☐ No If yes, list PERRP case number from log: _____

S & H Coordinator full name:	Work phone #:	
Job title:	Regular shift:	Days off:
S & H Coordinator's signature:		Date:

Ohio | Bureau of Workers' Compensation

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.

Last name, first name, middle initial | Social Security number | Marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed | Date of birth

Home mailing address | Sex ☐ Male ☐ Female | Number of dependents

City | State | 9-digit ZIP code | Country if different from USA | Department name

Wage rate $ _____ Per: ☐ Hour ☐ Month ☐ Week ☐ Year ☐ Other _____ | What days of the week do you usually work? ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ No
(If no, give accident location, street address, city, state and ZIP code)

Date of injury/disease | Time of injury _____ ☐ a.m. ☐ p.m. | If fatal, give date of death | Time employee began work _____ ☐ a.m. ☐ p.m. | Date last worked | Date returned to work

Date hired | State where hired | Date employer notified | State where supervised

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)

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.

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? ☐ Yes ☐ No | Is the injury causally related to the industrial incident? ☐ Yes ☐ No

E code | 11-digit BWC provider number | Date

Health-care provider signature

Employer info.

Employer policy number | Check if ☐ Employer is self-insuring ☐ 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? ☐ Yes ☐ No | Was employee hospitalized overnight as an inpatient? ☐ Yes ☐ No

If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code

☐ **Certification -** The employer certifies that the facts in this application are correct and valid.

☐ **Rejection -** The employer rejects the validity of this claim for the reason(s) listed below:

For self-insuring employers only

☐ **Clarification -** The employer clarifies and allows the claim for the condition(s) below:
☐ **Medical only** ☐ **Lost time**

Employer signature and title | Date | OSHA case number

Ohio | Bureau of Workers' Compensation

Physician's Report of Work Ability

Injured worker name			Claim number
Date of injury	Date of last appointment/examination	Date of this appointment/examination	Date of next appointment/examination

MEDCO-14 submission (Select one of the options below.)

1

☐ I have never completed a MEDCO-14. Proceed to section 2.
☐ I have previously completed a MEDCO-14, and all of the information remains the same. ***Proceed to and complete section 8.***
☐ I have previously completed a MEDCO-14, and I am providing updates to each section checked.

Employment/Occupation Complete this section and proceed to section 3 (Updates Yes ☐ No ☐)

2

Have you reviewed the description of the injured worker's job held on the date of injury (former position of employment)? Yes ☐ No ☐
If yes - please indicate who (select all sources) provided the job description ☐ Injured worker ☐ Employer ☐ MCO ☐ BWC

Work status/Injured worker's capabilities (Updates Yes ☐ No ☐)

3A

Does the injured worker have any work restrictions related to allowed conditions in the claim? Yes ☐ No ☐
If yes, proceed to section 3B.
If no restrictions, please indicate release to work date _____/_____/_____. ***Proceed to and complete sections 6 and 8.***

3B

If there are work restrictions, can the injured worker return to his/her job held on the date of injury (former position of employment)? Yes ☐ No ☐

If yes, please indicate release to work date: _____/_____/_____. ***Proceed to sections 3C, 5, 6, and 8.***

If no, please indicate when the injured worker initially could not do the job held on the date of injury. Date:_____/_____/_____.

Please estimate when the injured worker should be able to return to the job held on the date of injury for this period of restricted duty. Date:_____/_____/_____.

Proceed to section 3C.

3C

Please indicate which of the activities listed below the injured worker can perform (even if the response to 3B is "no".)

The injured worker can perform simple grasping with: ☐ Left hand ☐ Right hand ☐ Both

The injured worker can perform repetitive wrist motion with: ☐ Left hand ☐ Right hand ☐ Both

The injured worker's dominant hand is: ☐ Left ☐ Right

The injured worker can perform repetitive actions to operate foot controls or motor vehicles with: ☐ Left foot ☐ Right foot ☐ Both If the injured worker is taking prescribed medications for the allowed conditions in this claim, is the injured worker able to safely:

*Operate heavy machinery: ☐ Yes ☐ No *Drive: ☐ Yes ☐ No **Perform other critical job tasks as defined by any source listed above in section 2:* ☐ Yes ☐ No

Please indicate the following: N = Never, O = Occasionally, F = Frequently, C = Continuously										Lifting/carrying	N	O	F	C	Pushing/pulling	N	O	F	C
Activity	N	O	F	C	Activity	N	O	F	C	0 - 10 lbs.					0 to 25 lbs.				
Bend					Reach above shoulder					11 - 20 lbs.					26 to 40 lbs.				
Squat/kneel					Type/keyboard					21 - 40 lbs.					41 to 60 lbs.				
Twist/turn					Work with cold substances					41 - 60 lbs.					61 to 100 lbs.				
Climb					Work with hot substances					61 - 100 lbs.					100 + lbs.				

In an eight-hour workday, how many total hours is the injured worker able to:

Sit: ____ hours ☐ Continuously ☐ With break Walk: ____ hours ☐ Continuously ☐ With break Stand: ____ hours ☐ Continuously ☐ With break

In the space below please provide any additional information addressing the injured worker's capabilities and/or job accommodations which may not be addressed above. _____

_____

_____

_____

_____

_____

_____

Proceed to section 4.

Injured worker name	Claim number	Date of injury

Disability period information **(If 3B above is NO you must address all fields, including site/location if applicable)** (Updates Yes ☐ No ☐)

4A Complete the chart below and furnish the narrative description of the diagnosis(es), site/location, if applicable, and International Classification of Diseases (ICD) code(s) for the condition(s) being treated due to the work-related injury/disease. Please indicate if the condition is preventing the injured worker from returning to job duties he/she held on the date of injury.

Narrative description of the work-related allowed condition	Site/location if applicable	ICD code	Is the condition preventing full duty release to the job injured worker held on the date of injury?
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐

4B List all other relevant conditions that impact treatment of the conditions listed above (e.g., co-morbidities or not yet allowed conditions).

Clinical findings: Office notes can be referenced in lieu of writing clinical findings below. (Updates Yes ☐ No ☐)

5 The injured worker is progressing: ☐ As expected ☐ Better than expected ☐ Slower than expected
Provide your clinical and objective findings supporting your medical opinion outlined on this form. List barriers to return to work and reason, for the injured worker's delay in recovery.

Maximum medical improvement (MMI) (Updates Yes ☐ No ☐)

6 MMI is a treatment plateau (static or well-stabilized) at which no fundamental functional or physiological change can be expected within reasonable medical probability, in spite of continuing medical or rehabilitative procedures. Has the work-related injury(s) or occupational disease reached MMI based on the definition above? Yes ☐ No ☐
If yes, give MMI date: _____/_____/_____. If no, please provide the proposed treatment plan, including estimated duration of each treatment (attach additional sheet if necessary).

Note: An injured worker may need supportive treatment to maintain his or her level of function after reaching MMI. Thus, periodic medical treatment may still be requested and provided.

Vocational rehabilitation (Updates Yes ☐ No ☐)

7 Vocational rehabilitation is an individualized and voluntary program for an eligible injured worker who needs assistance in safely returning to work or in retaining employment. This program can be tailored around an injured worker's restrictions and may provide job seeking skills or necessary retraining. Is the injured worker a candidate for vocational rehabilitation services focusing on return to work?
Yes ☐ No ☐ If no, please explain why and provide your recommendations to help the injured worker return to employment.

Treating physician signature - mandatory

8 I certify the information on this form is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain payment as provided by BWC, or who knowingly accepts payment to which that person is not entitled, is subject to felony criminal prosecution and may be punished, under appropriate criminal provisions, by a fine or imprisonment or both.

Treating physician's name (please print legibly)		Address, city, state, nine-digit ZIP code, telephone and fax numbers
Treating physician's signature		
BWC provider (Peach) number	Date	

sedgwick | managed care ohio

Workers' compensation identification card

24-hour customer service: 888.627.7586

Employer name:

Policy number:

Please provide MEDCO-14 form with any physical restrictions, as employer may have modified duty available.

Please send all information within 24 hours of visit.

Injury report and FROI fax:	888.711.9284
Medical and authorization fax:	888.627.0074
Customer service:	888.627.7586
Prescription questions:	800.644.6292 (follow prompts)

Send all mail and medical bills to:

Sedgwick Managed Care Ohio
PO Box 1040
Dublin, OH 43017

This card is not a guarantee of coverage.