Self-Insured Injury Reporting

PACKET

THE OHIO STATE UNIVERSITY

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Office of Human Resources
Integrated Absence Management and Vocational Services
1590 North High Street, Suite 300
Columbus, Ohio 43201-2190
Phone: 614-247-myHR
Fax: 614-292-0271

On behalf of the Integrated Absence Management and Vocational Services team, I sincerely hope this letter finds you feeling better!

When you experience an injury or illness on the job, the Integrated Absence Management and Vocational Services team's goal is to ensure that your claim and return to work experience is positive and easy to understand. We will help you by managing your claim process and provide you with comprehensive case management services. Below are several tips to help you work through the workers' compensation claims process.

- It is important to read letters and respond to phone calls you may receive from organizations such as Sedgwick, the Ohio Bureau of Workers' Compensation, and the Ohio Industrial Commission. There may be deadlines that require action on your part. We will also be communicating with these organizations about your claim.
- When you are given restrictions from your doctor, we will attempt to accommodate your restrictions and assist you in regaining full duty status. If you are working with temporary restrictions, we will assume you are cleared for full duty status after the next scheduled doctor visit unless you submit further documentation. If you are taken off work by your doctor, it is your responsibility to notify your department about your timekeeping.
- If you remain off work for an extended period of time, you may also be eligible for additional disability benefits such as Short-Term (STD) and/or Long-Term Disability (LTD) benefits. If eligible, you have 12 months from your date of disability or absence from work to file for a STD or LTD claim.
- It is important for you to review the following University Policies as it relates leaves of absence and return to work. These Policies can be found on the OHR webpage: **https://hr.osu.edu/policies-forms.**
    - Paid Time off Policy 6.27
    - Unpaid Leave Policy 6.45
    - Family and Medical Leave Policy 6.05
    - Transitional Work Policy 2.45

You may need to make arrangements to ensure your health benefits continue while you are off work. Please contact Human Resources at 614-247-myHR for more information or visit
Leave of Absence.

There are several parties that will be involved in your claim process which are listed below for your convenience.

Office	Address	Phone Number	Subject
Human Resources, Integrated Absence Management and Vocational Services	1590 N. High Street Suite 300 Columbus, Ohio 43201	614-247-myHR	Family Medical Leave Return-to-Work or Remain-at -Work Services STD and LTD
Human Resources, Benefit Services	1590 N. High Street Suite 300 Columbus, Ohio 43201	614-247-myHR	Continuation of Health Care Benefits
Sedgwick	5500 Glendon Court Dublin, Ohio 43016	1-888-647-3815	Workers' Compensation Claim and Temporary Total Payment Questions
Human Resource Consultant (HRP)/Manager	Contact your unit's HRC and/ or Manager	Call your unit's HRC and/or Manager	time off approval/coordination Department Attendance Policy

We look forward to working with you!

In Better Health,

Integrated Absence Management and Vocational Services

IMPORTANT NOTICE FOR WORKPLACE INJURIES

In the event of a work-related injury, please see one of the medical providers recommended by your employer listed below and follow these important steps:

1. **Report the accident immediately to your supervisor.**
2. **Complete the Ohio State Employee Accident Report.**
3. **Select a medical provider** from the following list for immediate care.*
4. **For additional providers**, call Sedgwick at 1-888-647-3815 from 8:00 a.m. - 5:00 p.m.

In the event of a work-related life threatening injury or illness, seek medical care at the closest hospital emergency department regardless of a physician network affiliation or BWC certification status.

PROVIDER LISTINGS FOR WORKERS' COMPENSATION

The Ohio State University, University Health Services
1581 Dodd Drive, McCampbell Hall, Suite 201 Columbus, Ohio 43210
(614) 293-8146
Hours: Monday–Friday, 7:30 a.m.- 4:00 p.m.

OCCUPATIONAL MEDICINE

Located in McCampell Hall
1581 Dodd Dr., 3rd floor, suite 301, Columbus, Ohio 43210
(614) 688-6492
Hours: Monday–Friday, 7:30 a.m.- 400 p.m.

AFTER HOURS URGENT CARE

Martha Morehouse Medical Plaza
2050 Kenny Road 2nd Floor, Suite 2250, Pavilion
(614) 685-3357
Hours: Monday - Friday, 4:00 p.m. – 9:30 p.m.
Saturday & Sunday, 10 a.m. – 5:30 p.m.

Ohio State AfterHours Care Gahanna
920 North Hamilton Road, Suite 600
Gahanna, Ohio 43230
(614) 685-8888
Hours: Monday - Friday, 5:00 p.m. - 10:30 p.m.
Saturday & Sunday, 10:00 a.m. - 5:30 p.m.

OHIO STATE'S WEXNER MEDICAL CENTER - EMERGENCY

University Hospital
410 West 10th Avenue Columbus, Ohio 43210
(614) 293-8000

University Hospital East
181 Taylor Avenue Columbus, Ohio 43203
(614) 257 3000

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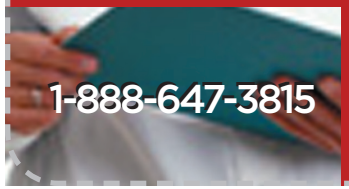
Integrated Absence Management and Vocational Services
The Office of Human Resources | The Ohio State University
1590 North High Street, Suite 300 Columbus, Ohio 43201
(614) 247-myHR | hr-integrateddisability@osu.edu https://hr.osu.edu/services/disability-benefits-leave-services/

**Employees may receive treatment from any BWC certified provider.*

The Ohio State University has selected the Sedgwick Family of Companies to manage your workers' compensation medical benefits. If injured at work, please follow these important steps:

1. **Immediately notify your supervisor.**
2. **Complete the enclosed Ohio State Employee Accident Report & Ohio Bureau of Workers' Compensation (BWC) First Report of Injury (FROI) form and fax to Ohio State within 24 hours of your workplace injury to (614) 292-0271 or email accidentreport@osu.edu**
3. **Show this card to every medical provider that treats your workplace injury.**

SELF-INSURED WORKERS' COMPENSATION I.D. CARD



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FOR WORKERS' COMPENSATION USE ONLY (SELF-INSURED)

The Ohio State University

BWC Self-Insured Policy # 20005754-0

Employer Contact: Integrated Absence Management and Vocational Services (614-247-myHR)

Attention Provider: Please notify Sedgwick at 1-855-223-9836 for pre-admission certification and prior authorization. All care to be based on workers' compensation treatment guidelines.

Billing Address (for all non-pharmacy bills): Sedgwick
P.O. Box 14661 Lexington, Kentucky 40512
Fax: (855) 223-9836

Attention Employee: This card may be used for conditions in your workers' compensation claim and is not a guarantee of coverage.

Pharmacy Benefits: Call Optum at 1-800-547-3330.

What happens when my physician releases me to work?

Integrated Absence Management and Vocational Services and your Sedgwick Claims Examiner will make every effort to help you return to your job as soon as possible. Ohio State's Transitional Work Policy (Policy 2.45 -https://hr.osu.edu/wp-content/ uploads/policy245.pdf) allows employees with temporary restrictions to continue to work throughout their recovery as they rehabilitate to their full capacity. Transitional work plans may include part-time work hours, reduced physical demands, or modified job tasks. A Disability Program Manager will maintain regular contact with you and your department to monitor progression and ensure a safe return to work. What if I am not satisfied with the medical treatment I am getting from my doctor?

If you are dissatisfied with your doctor, we encourage you to contact Integrated Absence Management and Vocational Services or your Sedgwick Claims Examiner. They will work with your treating physician on an appropriate treatment plan or, if necessary, will assist you in finding another doctor with whom you are more comfortable. You ultimately have the freedom to choose any licensed physician who will accept workers' compensation injuries.

What should I do if medical bills are sent to me?

If you receive bills from your doctor, medical facility or the hospital, please send them to:

Sedgwick
P.O. Box 14661
Lexington, KY 40512
Fax: (855) 223-9836

Who do I call if I have questions?

Contact Integrated Absence Management and Vocational Services at (614-247-myHR) Any questions concerning physician visits, change of physician or medical treatment requests may also be directed to your Sedgwick Claims Examiner at 1-888-647-3815.

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Employee Information

What to do in the event of an injury while working at The Ohio State University.

THE OHIO STATE UNIVERSITY'S GOAL IS TO PROVIDE A SAFE WORK ENVIRONMENT DESIGNED TO PREVENT WORKPLACE INJURIES.

HOWEVER, SHOULD YOU SUSTAIN A WORKPLACE INJURY THE FOLLOWING ARE ANSWERS TO TYPICAL QUESTIONS YOU MAY HAVE ABOUT YOUR ON-THE-JOB INJURY.

REPORT ALL INJURIES TO YOUR MANAGER OR SUPERVISOR IMMEDIATELY!

What if I need more than First Aid for my injury?

All accidents should be reported to your supervisor immediately. You shall complete an Ohio State Employee Accident Report and an Ohio Bureau of Workers' Compensation (BWC) First Report of Injury (FROI) form. Both forms are included in this packet.

In emergency situations, you should seek immediate medical attention and complete these forms as quickly as you are able.

In non-emergency situations, you may seek medical treatment from a BWC-certified provider of your choosing. Contact your Sedgwick Claims Examiner at 1-888-647-3815 to identify quality licensed providers in your area.

What happens to the First Report of Injury (FROI) form that I fill out with my physician?

Sedgwick will keep your FROI form for your workers' compensation on file. A copy of the FROI will also be kept on file with Integrated Absence Management and Vocational Services. In some instances, Sedgwick will also file a copy of the FROI with the BWC.

Who will pay for my Doctor's bills?

As a self insured employer, The Ohio State University will pay for authorized physician visits and related treatments if the injury was caused by an on-the-job accident. Sedgwick will issue payment for appropriate medical treatment directly to your physician on behalf of The Ohio State University.

How do I get my prescriptions filled?

This injury packet contains a Optum instant access card that will allow you to get a first fill on your initial prescription. First fill services are provided through the Optum Prescription program. If you require refills or additional medication for an allowed work-related injury, you will receive additional information in the mail from Optum. More information on how the prescription program works is available through the Workers' Compensation Department. The instant access cards expire at midnight on the date of service. If more medication is required, your Sedgwick Claims Examiner can enroll you in Optum's pharmacy program and you can receive a permanent card. You can always contact Optum at 1-800-547-3330 with any questions.

What happens if I cannot return to work?

The Ohio State University's Integrated Absence Management and Vocational Services team and your Sedgwick Claims Examiner will work with you and your doctor to monitor and maintain quality, appropriate treatment to ensure the most efficient and safe return to work. We will maintain communication with you throughout the duration of the claim.

Will I be paid for the time I miss from work due to my injury?

The Ohio State University will comply with BWC guidelines. If you miss work for more than seven (7) calendar days because of an *allowed* work-related injury, your time off work will be paid based upon a percentage of your average weekly earnings. In order to receive payments (referred to as Temporary Total Disability {TTD}), all of your time-off must be supported by your treating physician. You may request to use sick leave instead of receiving TTD. This request must be made in writing and a copy will be kept in your claim file.

When do I receive my wage payments?

If your treating physician has taken you off of work, has submitted the appropriate forms, and your claim is allowed, benefits will be paid within twenty one (21) days from the date the paperwork is received by Sedgwick.

Do I need a doctor's release to return to work?

If you have missed work as a result of your injury, your doctor must provide a medical release or fit for duty report in order to return to work. This injury packet contains a standard release form (Medco-14) that is commonly used to identify your work capabilities. **Have your doctor complete this form and fax directly to Sedgwick at (855) 223-9836 or you can return the form to Integrated Absence Management and Vocational Services.**

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Employee Accident Report

IMPORTANT: In the event of a work-related injury, the injured employee should obtain first aid as needed and notify the immediate supervisor of the incident as soon as practicable.

READ THESE INSTRUCTIONS BEFORE PROCEEDING

The Employee Accident Report MUST be completed for every work-related accident or illness, preferably within 24 hours of the incident. (Please print neatly in ink or complete electronically.)

Employee Responsibilities:

1. Seek medical treatment if necessary (see "Medical Treatment" section below).
2. Notify supervisor/designated charge person.
3. **Fully complete "Employee Information" and "Accident Information" sections. Sign and date the report.**
4. Give form to supervisor/charge person for signature, and completion of the Supervisor Accident Analysis Report (page 3).

For blood and body fluid exposures (BBFE): Report blood and body fluid exposures immediately to supervisor and *complete the BBFE Addendum to this report (page 4).* Wexner Medical Center personnel should refer to OneSource for Blood and Body Fluid Exposure Protocol. All others should call University Health Services at 614-293-8146 for instructions.

Supervisor/Manager/Charge Person Responsibilities:

1. If the employee needs or desires medical treatment, assist in the arrangement of appropriate care (see "Medical Treatment" section below).
2. Review the report, and sign as indicated in "SECTION 4: TO BE COMPLETED BY SUPERVISOR/CHARGE PERSON."
3. **Complete the "Supervisor Accident Analysis Report" (see page 3 of the report).**
4. Make a copy of this report for your record, and provide the original to the employee.

For health system employees injured during a patient transfer/repositioning mobility task, complete the Patient Handling Accident Investigation Checklist and follow the instructions on the form.

Immediately submit a copy of these completed forms to Integrated Absence Management and Vocational Services (IAMVS) by either:

- Email: accidentreport@osu.edu
- Fax: 614-688-8120

MEDICAL TREATMENT

For serious injuries that need emergency medical attention: please seek treatment at Ohio State's Wexner Medical Center Emergency Department, University Hospital East Emergency Department, or nearest medical facility.

Columbus campus employees should seek treatment for work-related injuries and/or illness at:

OSU University Health Services*
McCampbell Hall, 2nd floor
1581 Dodd Drive
Columbus, OH 43210
Phone: 614-293-8146

After Hours Care – Martha Morehouse Medical Plaza
2nd Floor, Suite OPAC 2250, Pavilion
2050 Kenny Road
Columbus, OH 43212
Phone: 614-685-3357

Ohio State AfterHours Care Gahanna
920 North Hamilton Road, Suite 600
Gahanna, Ohio 43230
614-685-8888

(Hours vary by location. Please visit https://hr.osu.edu/benefits/workers-compensation/ for information about our preferred medical providers)

Regional campus employees should seek treatment at the designated local health provider.

* There is no cost for medical treatment of work-related injuries at University Health Services.

WORKERS COMPENSATION RIGHTS

Employees have the right to apply for Workers' Compensation benefits. They have one year from the date of injury to do so. For more information regarding Workers' Compensation, call **614-292-3439**. For additional information and resources, visit **hr.osu.edu/benefits/workers-compensation**.

Submit this report to Integrated Absence Management and Vocational Services:
Email: accidentreport@osu.edu or Fax: **614-688-8120**

SECTION 1: EMPLOYEE INFORMATION (all fields required)

Employee's Full Name: First | M.I. | Last | OSU Employee ID# | ☐ Full Time ☐ Part Time

Home Mailing Address: Street | City | State | Zip

Home Phone | Date of Birth | Sex | Age

Job Title | Department | Work Phone | Date Hired

Work Address: Street | City | State | Zip

Supervisor's Full Name: First | Last | Supervisor's Phone

SECTION 2: ACCIDENT INFORMATION (provide as much detail as possible)

Accident date: _____ Accident time: _____ ☐ A.M. ☐ P.M. Time shift began: _____ ☐ A.M. ☐ P.M.

Date of death, if applicable: _____ Location of accident (room use/building/shop): _____

Briefly explain the accident and what was being done just prior: _____

Was this part of your normal job duty? ☐ Yes ☐ No

What object or substance directly harmed the employee?

_____

Type of injury or illness: _____

Witness (name and phone): _____

Did employee seek medical treatment? ☐ Yes ☐ No

If yes, where? _____

This report prepared by (name and phone, if different from injured employee):

_____

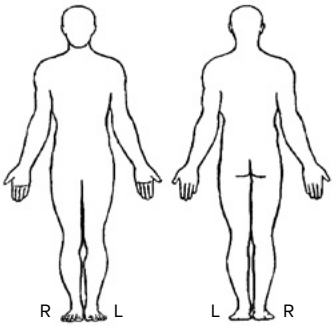
For blood/body fluid exposure, the Addendum (on page 4) must be fully completed.

Hospital Medical Record# of source patient: _____

Body part(s) affected/injured (circle on diagram)

	L	R
Eyes/Ears/Face	☐	☐
Neck/Shoulders/Arms/Elbows	☐	☐
Hips/Legs/Knees	☐	☐
Wrist/Hands/Fingers	☐	☐
Ankles/Feet/Toes	☐	☐
Back (Upper/Lower)	☐	
Head	☐	
Internal Organs	☐	

Other: _____



Please review the Medical Treatment information on page 1 of this form. **If no medical treatment is necessary or if treatment is sought somewhere other than University Health Services (UHS), submit a copy of this completed report to Integrated Absence Management and Vocational Services at Fax: 614-688-8120 or email:** accidentreport@osu.edu**.**

SECTION 3: EMPLOYEE AUTHORIZATION

I understand that it is my right to apply for Workers' Compensation benefits and that I have one year from the date of this accident to do so. I also authorize release of medical information regarding this accident to OSU BWC claim administrators.

_____ _____

Employee Signature | Date

SECTION 4: TO BE COMPLETED BY SUPERVISOR/CHARGE PERSON

This accident was reported to me on: Date: _____ Time: _____ Cost Center/Department#: _____

Is further investigation required? ☐ Yes ☐ No If yes, why: _____

_____ _____

Signature of Supervisor/Charge Person | Date

SECTION 5: TO BE COMPLETED BY HEALTH CARE PROVIDER

Treated by University Health Services? ☐ Yes ☐ No If no, treated by? _____

Medical provider printed name: _____ Medical provider signature: _____

Diagnosis/Assessment: _____

Body part(s) affected: _____ Date treated: _____

Reaggravation of a previous injury? ☐ Yes ☐ No If yes, date of initial injury: _____

☐ Full Duty ☐ Restricted Duty Date (if restricted, please use MEDCO-14): _____

OSHA/PERRP 300 Classification

Injury/Illness: (Check only 1 box) ☐ (1) Injury - All Other ☐ (2) Skin Disorder ☐ (3) Respiratory Condition ☐ (4) Poisoning ☐ (5) Hearing Loss ☐ (6) Illness - All Other

Severity: (check only 1 box): ☐ Not Recordable ☐ (J) Other Recordable Cases ☐ (I) Restrictions or Job Transfer ☐ (H) Days Away from Work ☐ (G) Death

Medical Record# _____

ATTENTION: This form contains information relating to employee's work-related injury and must be used in a manner that protects the confidentiality of the employee to the maximum extent possible. 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.

Submit copies to: (1) Integrated Absence Management and Vocational Services: Fax: **614-688-8120** or email: accidentreport@osu.edu (2) Supervisor/Department (3) Injured Employee

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Supervisor Accident Analysis Report

ALL parts of this form MUST be completed by the supervisor in conjunction with the Employee Accident Report.
This form must be submitted directly to Integrated Absence Management and Vocational Services upon completion.

SECTION 1: PARTICIPANT INFORMATION

Employee's Full Name: First _____ M.I. _____ Last _____ OSU Employee ID# _____

Supervisor's Full Name: First _____ M.I. _____ Last _____ Phone Number, Ext. _____

Date report completed: _____ Report completed on date of incident? ☐ Yes ☐ No

SECTION 2: PERSONAL PROTECTION

Required Personal Protective Equipment:

☐ Respiratory Protection ☐ Hearing Protection ☐ PPE-Other: _____
☐ Head Protection ☐ Hand Protection ☐ Face Protection
☐ Foot Protection ☐ Eye Protection ☐ Fall Protection

Was Required Personal Protective Equipment used?

☐ Yes ☐ No If not, explain: _____

SECTION 3: CONTRIBUTING FACTORS OR CONDITIONS

Period when incident occurred:

☐ Entering or leaving work ☐ During normal work shift ☐ Overtime or unscheduled work shift

Unsafe Conditions:

☐ Bypassed Guard or Device ☐ Inadequate Guard ☐ Lack of Required PPE ☐ Improper or Defective Clothing
☐ Defective Safety Device ☐ Inadequate Lighting ☐ Missing Safety Guard ☐ Unstable Walking Surface
☐ Defective Tool or Article ☐ Inadequate Ventilation ☐ Unguarded Hazard ☐ Improper Work Station Layout
☐ Training Deficiency (Specify): _____

Unsafe Actions:

☐ Bypassing a safety device ☐ Distractions or horseplay ☐ Operating at an unsafe speed ☐ Using equipment improperly
☐ Bypassing a policy or instruction ☐ Failure to use approved tools ☐ Servicing energized equipment ☐ Improper lifting technique
☐ Bypassing a safety guard ☐ Failure to wear approved PPE ☐ Using defective equipment ☐ Improper posture or ergonomics

Was a witness statement submitted with the Employee Accident Report? ☐ Yes ☐ No

Upon completion of this Supervisor Accident Analysis Report 1) the following details were found to have occurred, and 2) corrective measures will be taken as follows:

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Blood/Body Fluid Exposure Addendum

ALL parts of this form MUST be completed with as much detail as possible.
This form must be submitted directly to Integrated Absence Management and Vocational Services (not to supervisor).

SECTION 1: EMPLOYEE INFORMATION

Employee's Full Name: First _____ M.I. _____ Last _____ OSU Employee ID# _____

Occupation _____ Phone Number (for reporting lab results) _____ Date of Hire _____

Date of exposure: _____ Time of exposure: _____ Number of hours on duty: _____ Pregnant: ☐ Yes ☐ No

SECTION 2: BBFE INFORMATION

Specific location of exposure (room use and building): _____

Location type (patient room, laboratory, bathroom): _____

Cause of the exposure (splash, needlestick, bite): _____

Detailed account of the event (be as specific and detailed as possible): _____

In your opinion, what could have prevented this BBFE? (be specific): _____

SECTION 3: NEEDLESTICKS/SHARPS INJURIES

Was the sharp item: ☐ Contaminated ☐ Uncontaminated ☐ Unknown

Source of contamination (blood; other–please specify): _____

Depth of injury: ☐ No visible wound ☐ Superficial (surface scratch) ☐ Moderate (penetrated skin) ☐ Deep puncture or wound

Was the sharp being held? ☐ Yes ☐ No

If not, was the sharp: ☐ Hands too close to someone else handling sharp ☐ Being passed by someone else ☐ Dropped by someone else ☐ Set aside for future use ☐ Inappropriately discarded or left there by someone else

Type of sharp:

☐ Needle for blood draw
- ☐ Push button butterfly
- ☐ Multi sampling needle
- ☐ Slide safety butterfly
- ☐ ABG needle
- ☐ Syringe to draw cord blood
- ☐ Other

☐ Central line placement
- ☐ Lidocaine
- ☐ Introducer
- ☐ Scalpel
- ☐ Other

☐ Insulin pen
- ☐ Novo Nordisk Innolet (Reg or NPH)
- ☐ Novo Nordisk Flex Pen (Novolog Aspart or 70/30)
- ☐ Solostar (Lantus)
- ☐ Lilly (Humalog)

☐ Peripheral IV
- ☐ Angioset (butterfly)
- ☐ Angiocath (straight)

☐ Huber needle
- ☐ Safety
- ☐ Non-safety

☐ Suture needle

☐ Needle for injection ☐ EMG/SSEP needle ☐ Surgical instrument _____

If administering lidocaine, was needle: ☐ Being reused ☐ Set aside for reuse ☐ Stuck self while administering ☐ Recapping

If scalpel, was it a safety (retractable) scalpel? _____

Do you feel the device was defective?* _____

***If YES, please save device for University Health Services if possible.**

SECTION 4: SPLASHES

Was this exposure related to a splash? _____

Fluid Involved: ☐ Blood ☐ Urine ☐ Stool ☐ Vomitus ☐ Sweat, tears ☐ Saliva, sputum ☐ Vent condensation ☐ CSF, synovial, pleural, peritoneal, pericardial, or amniotic fluid

If urine, sweat, vomitus, stool, saliva, sputum, or vent condensation, was fluid visibly bloody? _____

What type of personal protective equipment (PPE) was worn during exposure? _____

☐ Gloves ☐ Gown ☐ Goggles ☐ Mask with face shield ☐ Mask

If splashed, fluid came in contact with: ☐ Intact skin ☐ Non-intact skin ☐ Eyes ☐ Nose ☐ Mouth ☐ Other

Did someone else inadvertently splash you? _____

If this BBFE was caused by a splash, list barrier protections that could have prevented it: _____

Bureau of Workers' Compensation

First Report of Injury, Occupational Disease, or Death (FROI)

Submit the form to BWC in one of the following ways. **Online:** bwc.ohio.gov, **Fax:** 1-866-336-8352, **Mail:** BWC Mail Processing Center, Attn: Claims, 30 W. Spring St. Columbus, OH 43215
Note: If you work for a self-insuring employer, submit this form to your employer's workers' comp manager.

Injured worker information

First name, middle initial, last name	Date of injury/disease	Social Security number	Date of birth	

Mailing address; add apartment number or P.O. Box, if applicable	City	State	ZIP code

Sex ☐ Male ☐ Female	Email address	Home phone number	Cell phone number

Employer name	Employer address	City	State	ZIP code

Was the injured worker hired through a temp agency? ☐ Yes ☐ No If yes, name of temp agency	Mark the days of the week you usually work ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat	Regular work hours (include a.m. p.m.) From To

Date hired	Job title	State where hired	State where supervised	Wage rate; $ per hour	Number of hours scheduled to work the week of this injury

Work number for call-offs (Number injured worker calls to reach supervisor)	Part(s) of body affected (For example: Left knee, right index finger)

Accident description (Describe the sequence of events that directly caused the injury or death.)	**Will the incident cause the injured worker to miss 8 or more days from work?** ☐ Yes ☐ No

Injured worker start time _____ ☐ am ☐ pm	Time of injury _____ ☐ am ☐ pm	Date employer notified	Was any part of a workday missed due to the injury? ☐ Yes ☐ No	Date last worked	If the injured worker has returned to work, provide the date.

Was the place of the accident or exposure on employer's premises? ☐ Yes ☐ No If no, give accident location, street address, city, state, and ZIP code.	Was injured worker hospitalized overnight? ☐ Yes ☐ No

Initial treatment date	Health-care office/Facility name	Treating physician/Provider name	Telephone number	Fax number

Health-care office/Facility street address	City	State	ZIP code

If the injury resulted in death, answer the following.

Date of death Decedent's marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Decedent's number of dependents

To be completed by the injured worker

By signing this form, I:

- **Elect to only receive compensation, benefits, or both provided for in this claim under Ohio's workers' compensation laws.**
- **Understand, waive, and release my right to receive compensation and benefits under the workers' compensation laws of another state for the injury, occupational disease, or death resulting from an injury or occupational disease for which I am filing this claim.**
- **Confirm I have not received compensation and benefits under the workers' compensation laws of another state for this claim, and I will notify BWC immediately upon receiving any compensation or benefits from any source for this claim.**
- **Will not file and have not filed a claim in another state for the injury, occupational disease, or death resulting from an injury or occupational disease for which I am filing this claim.**

Furthermore, I understand that:

- Upon request, my treating providers may submit to BWC, my employer, my employer's managed care organization or qualified health plan, or their authorized representatives medical, psychological, psychiatric, or vocational documentation relating causally or historically to physical or mental injuries relevant to this claim and necessary for me to obtain medical services, benefits, or compensation.
- Proper administration of this claim may require BWC to review and share with the employers of record, their authorized representatives, or my authorized representative any information or record maintained in this claim, or in my previous or future claims.
- Information or records maintained in my previous or future claims may affect decisions made in this claim.
- Any person who obtains compensation or benefits from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false statements, or accepting compensation or benefits to which he or she is not entitled, is subject to felony criminal prosecution for fraud (Ohio Revised Code 2913.48).

I certify that I have read, understand, and agree to the above statements and the information contained on this form is true and accurate to the best of my knowledge.

Injured worker signature	Date

To be completed by the treating provider

Diagnosis(es)-narrative description including as appropriate, the location and body part, and ICD code(s). **Important:** If there is an injury, list the condition or disease, not the symptoms or exposure. For example, "sprain right knee" not "pain right knee", "toxic effect of ammonia" not "exposure to ammonia", "contusion to the head" not "headache".

Initial treatment date	Are the medical conditions you have listed above causally related to the reported work-related accident or occupational disease? ☐ Yes ☐ No Are you the physician of record? ☐ Yes ☐ No

Treating physician/Provider's name (Print)	Treating physician/Provider's signature	BWC provider number	Date

To be completed by the employer

Employer name	Employer county	Phone number	Fax number	Email address

Employer policy number	Federal ID number	Injured worker is (Check box, if applicable.) ☐ Owner/Sole proprietor ☐ Partner ☐ Individual incorporated as a corporation

For all employers: ☐ Certification – I certify the facts in this application are correct and valid. ☐ Rejection – I reject the validity of this claim for the reason(s) listed below.
For self-insuring employers only: ☐ Medical only ☐ Lost time
Clarification – I clarify and allow the claim for the condition(s) below.

Employer signature and title	Date

To be completed by the submitter if the form is completed by someone other than the injured worker, treating physician, or employer

Signature of person completing this form	Date

Ohio | Bureau of Workers' Compensation

Authorization to Release Medical Information

Instructions

*You can obtain this form online at **ohiobwc.com***

- 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.

Injured worker name (first, M.I., last)		Date of injury		Claim number
Address	City		State	Nine-digit ZIP code
Employer name	Employer MCO or QHP			

I, the above-named injured worker, understand I am allowing the Opportunities for Ohioans with Disabilities 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. _____

_____.

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 appropriately checking Yes or No on each section.

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 physical or health restrictions related to allowed conditions in the claim? Yes ☐ No ☐
If yes, are the restrictions: ☐ Permanent ☐ Temporary ***Proceed to section 3B.***
If no, please check the box to indicate the injured worker is released to work as of the date of this exam. ☐ ***Proceed to section 8.***

3B

If there are restrictions, can the injured worker return to the full duties of his/her job held on the date of injury (former position of employment)? Yes ☐ No ☐
If yes, please check the box to indicate that the injured worker is released to work as of the date of this exam. ☐ ***Proceed to section 8.***
If no, please indicate when the injured worker could not do the job held on the date of injury for this period of restricted duty.
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.)
If the injured worker is not released to the former position of employment but may return to available and appropriate work with restrictions, please indicate the possible return to work date:_____.
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, can the injured worker 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.	☐	☐	☐	☐

How many total hours can the injured worker work: _____ per week _____ per day?
In an eight-hour workday, how many total hours can the injured worker: Sit: ____ hours ☐ Continuously ☐ With break
Walk: ____ hours ☐ Continuously ☐ With break Stand: ____ hours ☐ Continuously ☐ With break
Does the injured worker have any functional restrictions based only on allowed psychological conditions? ☐ Yes ☐ No If Yes, please describe in space provided below. Note: If Yes is indicated please reference the MEDCO-16 as needed.
Additionally, in this space, 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 information (If 3B above is "NO" or dates updated - all 4A fields, including site/location if applicable must be completed) (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: You can reference office notes 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	
Treating physician's signature			
BWC provider (Peach) number	Date	Telephone number	Fax number

PO Box 152539
Tampa, FL 33684-2539

MAKING IT EASY TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured person:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. In most cases, the pharmacy will fill the prescription at no cost to you.

If your workers' compensation claim is accepted, you will receive a permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Employer:

Immediately upon receiving notice of injury, fill in the information below and give this form to the employee.

Finding a network pharmacy

Most pharmacies and all major chains are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

OPTUM® sedgwick®

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Sedgwick — CARRIER/TPA

THE OHIO STATE UNIVERSITY — EMPLOYER

INJURED PERSON NAME

Please provide directly to Pharmacist

SOCIAL SECURITY NUMBER — DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Call 1-800-964-2531 to establish First Fill benefit eligibility and to obtain the ID# for online adjudication of approved benefits for the injured individual.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

tmesys®

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