**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 Victoria Bates within 48 hrs)*

Employee Name Image Date of Incident Image Time of Incident Image

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

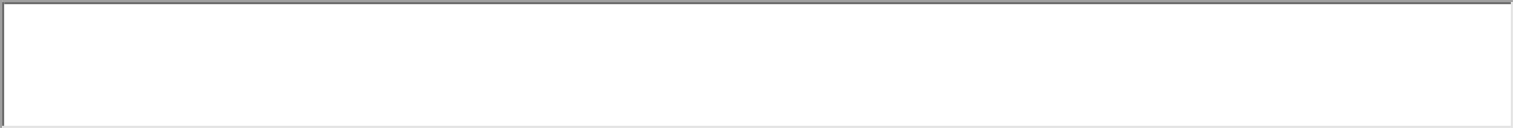
Work Dept./Div Image Date Hired Image Date of Birth Image Age Image Sex (M/F) Image Employee Social Security Number Image Job Classification Image

Employee Home Address Image City Image State Image Zip Image

Person Completing Form Image Date Reported To Supervisor Image

Was Incident Reported Immediately? ImageImage To Whom Image

If no, explain Image

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 Image Date Signed Image

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

Body Part Image Image Image Image

ImageImage Image Image Image ImageImage

Image Image Image

Type of Incident Image Image Image

Image Image Image

Image Image Image

ImageImage Image

Image Image ImageImage

Type of Injury Image Image Image Image

Image Image Image Image

Image Image Image Image

Image Image Image Image

ImageImage

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

Where was treatment given? Image Image Image

Worksite first aid provided by Image

Describe worksite first aid treatment Image

Medical Provider's name if treated off-site Image

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

Medical Provider's Address Image

Was employee treated in an emergency room? Image Image

Was employee hospitalized overnight as an in-patient? Image Image

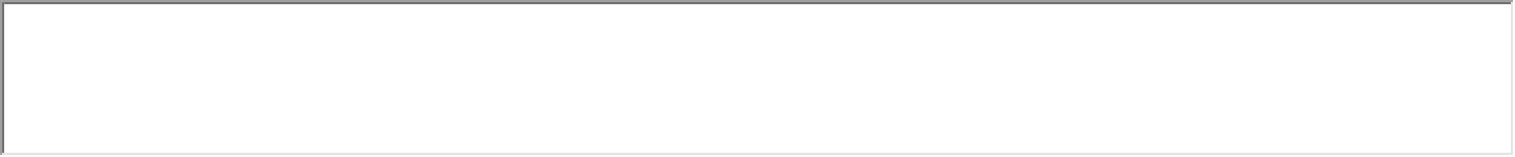
How was the incident verified? If possible, please attach statements.

Image Image Name of Witnesses Image

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

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

Supervisor Signature Image Date Signed Image

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