TWINSBURG CITY SCHOOL DISTRICT

11136 Ravenna Road • Twinsburg OH 44087-1022
Phone: (330) 486-2000
Fax: (330) 425-7216

Kathryn Powers, Superintendent
Martin Aho, Treasurer
Jennifer Farthing, Director of Curriculum

Blenda McKinney, Director of Human Resources
Denise Traphagen, Director of Pupil Personnel
Chad Welker, Director of Business Services

INJURY PACKET INSTRUCTIONS

Any employee incurring an injury while engaged in his/her performance of District duties shall abide by the following procedures:

1. The injured employee shall report to his/her supervisor's office obtain an Injury Packet and complete the following forms before reporting to an approved physician.

    - Incident Report Form
    - Witness Statement
    - Provider Listing
    - BWC FROI (form #1101)
    - BWC Authorization to Release Medical Information (form #C101)
    - Sick Leave Option Form

    The only exception will be if the injury is of such a nature that it requires immediate emergency attention. In that case, treatment should be undertaken and a report of the accident made to the supervisor's office at the earliest opportunity.

    Except in emergencies, staff members are requested to use only hospitals and physicians approved by the Bureau of Workers Compensation and insurance carrier in the treatment of work-related injuries. Each school and department shall maintain a list of those hospitals and physicians approved for treatment of school employees.

2. Upon arrival at a medical provider the employee should;

    - Inform the physician that this is a work related injury
    - Inform the physician that CompManagement Health Systems is our Managed Care Organization (MCO) and to call 1-888-247-4800 to report treatment.

3. Upon completion of medical care by a specialist, the employee must first report back to the treating physician for release prior to returning to work.

4. If medical treatment is required for two weeks or more the employee is eligible to participate in the Transitional Work Program.

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INCIDENT REPORT FORM

EMPLOYEE INFORMATION

Injured Employee's Name

Injured Employee's Position

Injured Employee's Phone #

Injured Employee's Address

Supervisor Notified

Date/ Time Supervisor Notified

ACCIDENT INFORMATION

Location Injury Occurred

Date/ Time of Injury

Describe Nature and Cause of Injury in Detail (Please Print or Type)

Facility Taken To

Facility Address

Facility Phone #

Treating Physician

Employee Completing this Report - Title

Title

Date Received By Accountant

Accountant Signature

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Transitional Work Provider Listing

Provider	Location	Address		Phone #	Fax #
Closest To Schools					
University Hospitals Twinsburg Urgent Care	Twinsburg Health Center	8819 Commons Blvd Suite 101	Twinsburg, OH 44087	(330) 405-1500	(440) 349-8154
Hours of Operation	Monday-Friday: 9 a.m.-9 p.m.	Saturday-Sunday: 9 a.m.-5 p.m.	Holidays: 9 a.m.-3 p.m.		
Other Locations					
Cleve Clinic - Southe Point Hospital Urgent Care	Twinsburg Medical Ctr	2365 Edison Blvd (Rt 91)	Twinsburg, OH 44087	(330) 425-4047	
Cleve Clinic - Southe Point Hospital	Southe Point Hospital	20000 Harvard Rd	Warrensville Hghts, OH 44122	(216) 491-6000	
Cleve Clinic - Bainbridge Urgent Care	Bainbridge Center Bldg	17747 Chillicothe Rd Suite #100	Bainbridge, OH 44023	(440) 543-8855	(440) 543-2470
Cleve Clinic - Solon Family Health Center	Cleveland Clinic Bldg	29800 Bainbridge Road	Solon, Ohio 44139	(440) 519-6800	(800) 648-0022
Cleve Clinic - Marymount Hospital	Marymount Hospital Bldg	123000 McCracken Road	Garfield Heights, OH 44125	(216) 518-3655	(216) 518-3675
Center for Corporate Health (SYST)C)	at Sagamore Hills Medical Ctr	863 West Aurora Road	Sagamore Hills, OH 44067	(330) 468-0194	(330) 467-3830
Med Group of University Heights	Med Source One building	2174 Warrensville Center Road	University Heights, Ohio 44118	(216)-381-9000	(216) 381-2151
Med Source of Valley View	Med Source One building	8555 Sweet Valley Drive	Valley View, Ohio 44125	(216) 328-2240	(216) 642-7980
Med Group of Stow	Med Source One building	3913 Darrow Road, Suite 100	Stow, Ohio 44224	(330)-6887900	(330) 688-1866
Med Group of Parma Heights	Med Source One building	6420 York Road	Parma Heights, Ohio	(440)-886-1800	(440) 886-4283
St Vincent Charity Hospital	Solon Med Campus Occ Med Ctr	33001 Solon Road	Solon, Ohio 44139	(440) 349-1796	(440) 349-8154

Ohio | Bureau of Workers' Compensation

First Report of an Injury, Occupational Disease or Death

This form can be completed and submitted online at **www.bwc.ohio.gov**

Report your injury by completing all three sections of this form

1. Complete as much of all three sections of this form as possible to reduce the time necessary in determining the claim. If this form is completed by the injured worker at the first visit to a medical provider, the injured worker may give the FROI to the provider to complete the treatment information section. The provider can then submit the FROI to the MCO.
2. Deliver, mail or fax the completed document to your employer or your employer's managed care organization (MCO).
3. If you do not know your employer's MCO, contact BWC at **1-800-644-6292** and follow the prompts, or use the MCO on BWC's Web site at **www.bwc.ohio.gov.**
4. If you are unable to determine your MCO, mail or fax this form to the BWC customer service office closest to your home. For information on your local customer service office, please visit **www.bwc.ohio.gov.**, or call **1-800-644-6292.**

Injured workers employed by a self-insuring employer

- Complete this form and give to your employer.
- Your employer should be able to tell you if he or she is a self-insuring employer.
- If your employer is self-insuring and you file this information with BWC, processing delays may occur.

For assistance in completing this form, call your BWC customer service office Monday through Friday, 8 a.m. – 5 p.m.

Cambridge
61501 Southgate Road
Cambridge, OH 43725-9114
Phone: 740-435-4200
Fax: 866-281-9351

Canton
339 E. Maple St., Suite 200
North Canton, OH 44720-2593
Phone: 330-438-0638
Toll free: 800-713-0991
Fax: 866-281-9352

Cleveland
615 Superior Ave. W.
Cleveland, OH 44113-1889
Phone: 216-787-3050
Toll free: 800-821-7075
Fax: 866-336-8345

Columbus
30 W. Spring St.
Columbus, OH 43215-2256
Phone: 614-728-5416
Fax: 866-336-8352

Dayton
3401 Park Center Drive, Suite 100
Dayton, OH 45414-2577
Phone: 937-264-5000
Fax: 866-281-9356

Garfield Heights
4800 E. 131 St., Suite A
Garfield Heights, OH 44105-7132
Phone: 216-584-0100
Toll free: 800-224-6446
Fax: 866-457-0590

Cincinnati–Governor's Hill
8650 Governor's Hill Drive
Cincinnati, OH 45249-1369
Phone: 513-583-4400
Fax: 866-281-9357

Lima
2025 E. Fourth St.
Lima, OH 45804-4101
Phone: 419-227-3127
Toll free: 888-419-3127
Fax: 866-336-8346

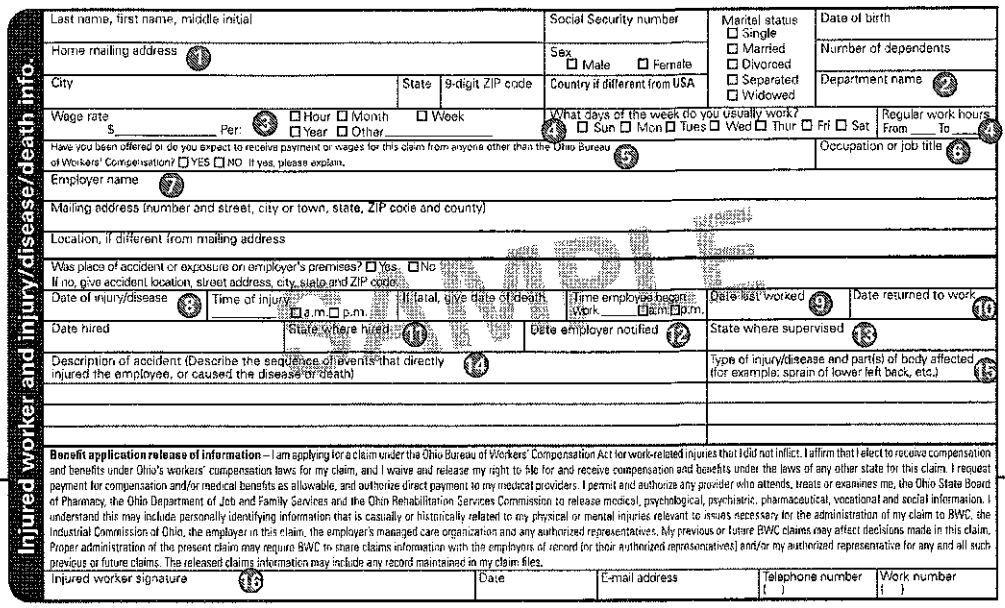
Mansfield
240 Tappan Drive, N., Suite A
Ontario, OH 44906-1366
Phone: 419-747-4090
Fax: 866-336-8350

Portsmouth
1005 Fourth St.
Portsmouth, OH 45662-4315
Phone: 740-353-2187
Fax: 866-336-8353

Toledo
P.O. Box 794
1 Government Center, Suite 1136
Toledo, OH 43697-0794
Phone: 419-245-2700
Fax: 866-457-0594

Youngstown
242 Federal Plaza, W., Suite 200
Youngstown, OH 44503-1206
Phone: 330-797-5500
Toll free: 800-551-6446
Fax: 866-457-0596

Completion instructions
(continued)



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 (1)			Sex ☐ Male ☐ Female		Number of dependents
City	State	9-digit ZIP code	Country if different from USA		Department name (2)
Wage rate $_____ Per: (3) ☐ Hour ☐ Month ☐ Week ☐ Year ☐ Other_____			What days of the week do you usually work? (4) ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat		Regular work hours From ____ To ____ (4)
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. (5)					Occupation or job title (6)
Employer name (7)					
Mailing address (number and street, city or town, state, ZIP code and county)					
Location, if different from mailing address					
Was 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 (8)	Time of injury _____ ☐ a.m. ☐ p.m.	If fatal, give date of death	Time employee began work _____ ☐ a.m. ☐ p.m.	Date last worked (9)	Date returned to work (10)
Date hired	State where hired (11)		Date employer notified (12)	State where supervised (13)	
Description of accident (Describe the sequence of events that directly injured the employee, or caused the disease or death) (14)				Type of injury/disease and part(s) of body affected (for example: sprain of lower left back, etc.) (15)	

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 (16)	Date	E-mail address	Telephone number ( )	Work number ( )

Injured worker and injury/disease/death info.

1. Home address: Enter the home address where the injured worker lives. Include the apartment number, if applicable.
   - If the post office does not deliver mail to the home address, list the mailing address instead of the home address.
2. Department name: Enter the injured worker's department or area name where he/she normally reports for work.
3. Wage rate: Enter the injured worker's rate of pay, and then select how often it is received. (If the pay rate being reported is not hourly, report the gross amount.)
   - If eight or more days of work will be missed, BWC needs wage information for the 52 weeks prior to the date of injury. Submit wage information using employer payroll reports, wage statement (BWC form C-94-A), W-2s, etc.
4. What days of the week do you usually work? What are your regular work hours: Enter the days and hours the injured worker normally works.
   - If the days worked vary from week to week, list the number of hours worked in an average week.
5. Wages: If you received wages during disability, please explain.
6. Occupation or job title: Enter the injured worker's type of occupation or actual job title at the time of injury, occupational disease or death.
7. Employer name: Enter the name of the injured worker's employer at the time of the injury, occupational disease or death.
8. Date of injury/disease: Enter the date injured worker was injured. OR
   If the injured worker contracted an occupational disease, determine which of the following happened most recently:
   - The occupational disease was diagnosed by a medical provider;
   - The first medical treatment;
   - The injured worker first quit work, due to the occupational disease.

   Enter this as the date of occupational disease.
9. Date last worked: Enter the last day worked as a result of this injury, occupational disease or death.
10. Date returned to work: Enter the date the injured worker returned to work after the injury or occupational disease.
11. State where hired: Enter the state where the injured worker was hired by the employer listed on this application.
12. Date employer notified: Enter the date the employer was notified of the injury, occupational disease or death.
13. State where supervised: Enter the state where the injured worker was supervised by the employer listed on this application.
14. Description of accident: Describe in detail the events that caused the injury, occupational disease or death. Attach additional sheets, if necessary.
15. Type of injury/disease and part of body affected: Describe the nature of the injury, occupational disease or death.
    Indicate the part(s) of body injured, affected or that caused the death.
    Examples:
    - Laceration of first toe, left foot;
    - Sprain of lower right back; etc.
16. Injured worker signature (injured workers only): Please read the Benefit application/medical release information before signing and dating this form.

Instructions continued on last page

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.

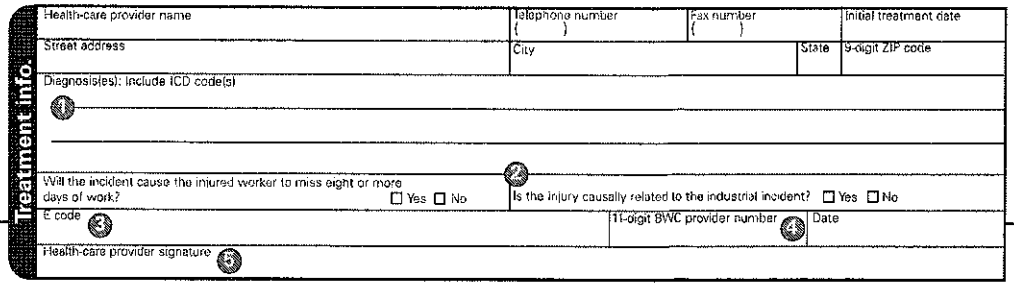
☐ **Rejection** - The employer rejects the validity of this claim for the reason(s) listed below:

For self-insuring employers only

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

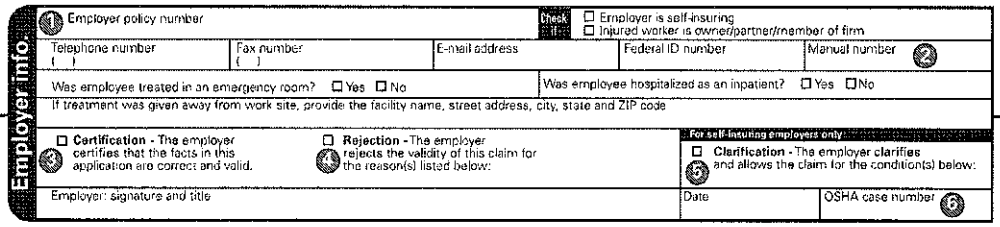
Employer signature and title	Date	OSHA case number

Completion instructions
(continued)



Treatment info.

1. Indicate the diagnosis and ICD codes for conditions being treated as a result of the injury.
2. Indicate the treating provider's medical opinion that the injury sustained is causally related to the industrial incident, that the injury could result from the method (manner) of the accident, as described by the injured worker. It must be clear that the diagnosis in all probability occurred as a result of the injury.
3. Providing a valid E code will enable us to determine the claim more quickly and efficiently.
4. Enter the physician's or health-care provider's 11-digit BWC-assigned provider number.
5. Signature of the health-care provider completing this form.



Employer info.

1. Enter the employer's BWC-assigned policy number, which is located on the BWC certificate of coverage.
2. Enter the four-digit code that indicates the injured worker's job classification, located on the semiannual payroll report.
   - If you do not know the injured worker's manual number, call **1-800-644-6292** and follow the prompts.
3. If certification is selected and the claim is allowed, it will promptly be paid. Employers certifying a claim waive both the notice of receipt and notice of first order of compensation.
4. If rejection is selected, use the space provided to list the reasons for rejection. Attach additional sheets, if necessary.
5. Self-insuring employers that choose to clarify certification may use the space provided. Attach additional sheet, if necessary.
6. If this is an OSHA-reportable injury, include the case number assigned by the employer. This form meets OSHA 301 requirements and may be used in lieu of the OSHA 301 when reporting recordable injuries and illnesses to the federal government.

Note:
If your employee misses eight or more days of work, BWC will need wage information for the 52 weeks prior to the date of injury. Submit wage information using employer payroll reports, wage statement (BWC form C-94-A), W-2s, etc.

Ohio | Bureau of Workers' Compensation

Authorization to Release Medical Information

Instructions

You can obtain this form online at ***www.bwc.ohio.gov***

- 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. _____

_____

Twinsburg City School District

11136 Ravenna Road ·Twinsburg, Ohio 44087-1022
Phone: (330) 486-2000
Fax: (330) 425-7216

SICK LEAVE OPTION FORM

Injured Employee's Name	Date of Injury
Injured Employee's Signature	Title

The purpose of this document is to notify any eligible employee who sustains a compensable workers' compensation injury of their right to use accrued sick leave or the option of applying for Bureau of Workers' Compensation disability (temporary or toal compensation) benefits.

The injured worker can, however, notify the employer of an election to stop using sick leave at a future date. The worker then files a request to the BWC for temporary total compensation accompanied by a statement from the employer as to the last day sick leave is paid.

Please complete one box only.

Option 1	Option 2
I acknowledge the above and elect to receive accrued sick leave in lieu of compensation form the BWC. I also understand compensalton can be elected for a period subsequent to sick leave benefits but may not overlap.	I acknowledge the above and elect to receive temporary total compensation from the Bureau of Workers' Compensation for which I may be eligible.
Employees's Signature	Employees's Signature
Date	Date