TWINSBURG CITY SCHOOL DISTRICT

11136 Ravenna Road • Twinsburg OH 44087-1022
Phone 330.486.2000 • Fax 330.425.7216

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 the 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 – Name

Employee Completing this Report - Title

Date Received by Accountant

Accountant Signature

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INCIDENT WITNESS STATEMENT

Witness Name _____ Title _____

Injured Employee's Name _____ Date of Injury _____

Did you witness the injury? _____

Were there any other witnesses? _____

If yes please name: _____

What date and time were you first aware that your co-worker was injured? _____

Please describe the nature and cause of the injury in your own words:

_____

_____

_____

_____

_____

_____

_____

Employee Signature _____ Date Completed _____

Date Received By Accountant _____ Accountant Signature _____

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TWINSBURG SCHOOLS OCCUPATIONAL HEALTH CLINICS

SUMMIT COUNTY

UH Twinsburg Health Center Urgent Care
8819 Common Blvd., Suite 100
Twinsburg, OH 44087
(330) 405-1500

Western Reserve Hospital Stow Urgent Care & Occupational Medicine
3913 Darrow Road, Suite 100
Stow, OH 44224
(330) 688-7900

Summa Health Fairlawn Urgent Care
2875 West Market Street, Suite B
Fairlawn, OH 44333
(330) 864-1916

Summa Health Cuyahoga Falls Medical Center
1860 State Road, Suite C
Cuyahoga Falls, OH 44223
(330) 922-4648

Concentra Urgent Care
1450 Firestone Parkway
Akron, OH 44301
(330) 724-3345

CUYAHOGA COUNTY

Cleveland Clinic Company Health Care
5595 Transportation Blvd., Suite 220
Garfield Heights, OH 44125
(216) 587-5431

Concentra Urgent Care
7730 First Place, Suite D
Oakwood Village, OH 44146
(440) 735-0438

St. Vincent Charity Medical Center Occupational Health
2475 E 22nd Street, Suite 310
Cleveland, OH 44115
(216) 363-2691

St. Vincent Charity Medical Center Occupational Health – Solon
33001 Solon Road, Suite 220
Solon, OH 44139
(440) 349-1796

MEDGroup
13916 Cedar Road
University Heights, OH 44118
(216) 397-9000

Ohio | Bureau of Workers' Compensation

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

Instructions

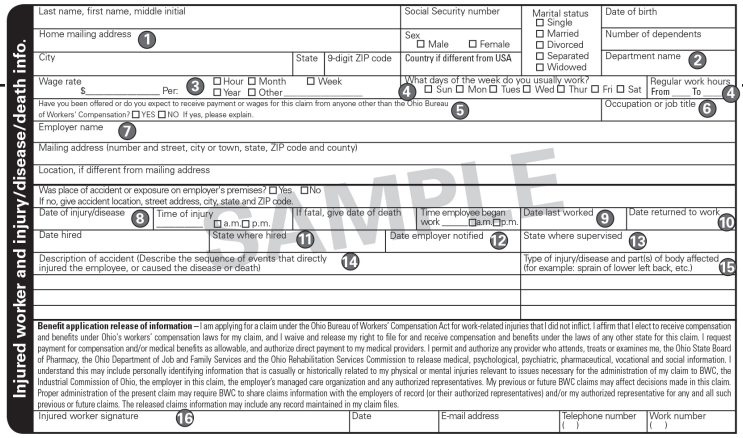
To expedite your claim, you can complete and submit this form online at **www.bwc.ohio.gov.**

- If submitting the hard copy form, complete as much of this form as possible to reduce the time necessary for BWC to determine the claim.
- If you complete this form at your first visit to a medical provider, the provider should complete the treatment information section. The provider can then submit the FROI to the managed care organization (MCO).
- You should also report this injury to your employer.

Where do I file the hard copy FROI?

For injured workers whose employer is self-insured: Send the form to your self-insuring employer. If you are not sure if your employer is self-insured, ask your employer.

For all other injured workers: Fax the form to 1-866-336-8352, or send it to your local BWC customer service office.



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 ( )

SAMPLE

Injured worker and injury/disease/death info.

(1) Home address: Address where you live, including the apartment number, if applicable.
- If the post office does not deliver mail to the home address, list the mailing address.

(2) Department name: Enter the department where you normally report for work.

(3) Wage rate: Enter your rate of pay, then select how often you receive it. (If the pay rate reported is not hourly, report the gross amount.)
- If you will miss eight or more days of work, BWC needs wage information for the 52 weeks prior to the date of injury.

(4) What days of the week do you usually work? What are your regular work hours: Enter the days and hours you normally work.
- 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 type of occupation or job title at the time of injury, occupational disease or death.

(7) Employer name: Enter the name of your employer at the time of the injury, occupational disease or death.

(8) Date of injury/disease: Enter the date you were injured, or if you 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.
For death claims, enter the injured worker date of death.

(9) Date last worked: Enter the last day worked as a result of this injury, occupational disease.

(10) Date returned to work: Enter the date you returned to work after the injury or occupational disease.

(11) State where hired: Enter the state where the employer listed on this application hired you.

(12) Date employer notified: Enter the date that you notified the employer of the injury, occupational disease or death.

(13) State where supervised: Enter the state where the employer listed on the application supervised you.

(14) Description of accident: Describe in detail the events that caused the injury, occupational disease or death.

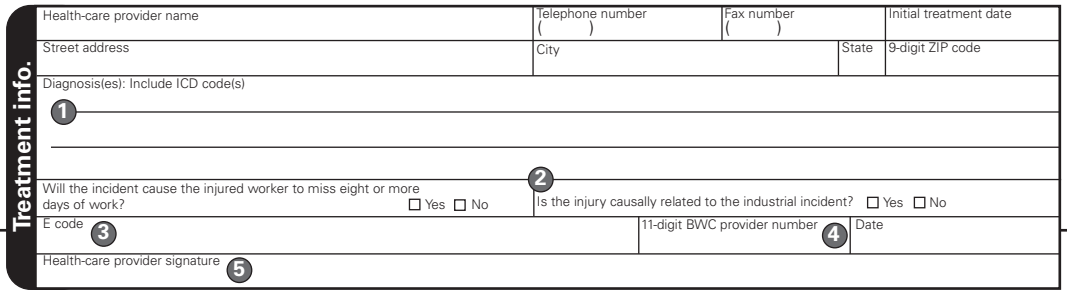
(15) Type of injury/disease and part of body affected: Describe the nature of the injury, occupational disease or death. Indicate the part(s) of body injured, affected or that caused the death.

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.

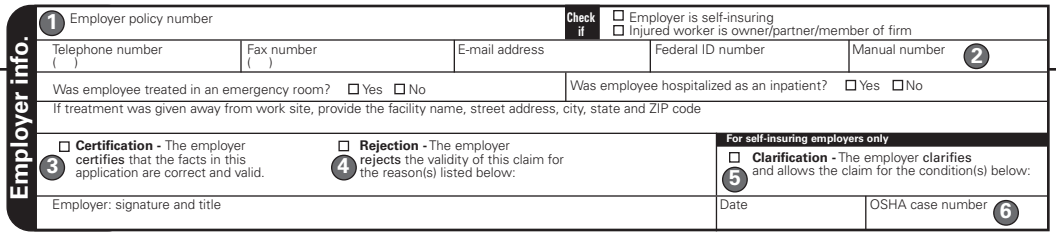
Completion instructions

(continued)



Treatment info.

1. Indicate the diagnosis and ICD codes for conditions 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.
   - If you do not know the injured worker's manual number, call **1-800-644-6292,** and follow the prompts.
3. If you select certification, and BWC allows the claim, BWC will promptly pay it. Employers certifying a claim waive both the notice of receipt and notice of first order of compensation.
4. If you select rejection, 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 sheets, if necessary.
6. If this is an Occupational Safety and Health Administration (OSHA)-reportable injury, include the case number assigned by the employer. This form meets OSHA 301 requirements.You may use it 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's Employer Report of Employee Earnings), W-2s, etc.

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

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.

C-101 - Authorization to Release Medical Information: Injured workers should use this form to authorize the release of medical records relative to their work-related injury(s). By signing this form, the injured worker authorizes medical providers who have rendered services relative to the injury to release information to BWC, the Industrial Commission, the employer, the managed care organization (MCO) or qualified health plan (QHP) and any authorized representatives. The form is intended to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), although BWC is exempt from HIPAA requirements.

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. _____

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SICK LEAVE OPTION FORM

Injured Employee's Name _____ Date of Injury _____

Injured Employee's Signature _____ Injured Employee's 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 total 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 or Option 2)

Option 1

I acknowledge the above and elect to receive accrued sick leave in lieu of compensation from the BWC. I also understand compensation can be elected for a period subsequent to sick leave benefits but may not overlap.

_____
Employee's Signature

_____
Date

Option 2

I acknowledge the above and elect to receive temporary total compensation from the Bureau of Workers' Compensation for which I may be eligible.

_____
Employee's Signature

_____
Date