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-OHIOBWC and follow the prompts, or use the MCO on BWC’s website at ohiobwc.com.

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 ohiobwc.com, or call 1-800-OHIOBWC.

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
  - 6150 Southgate Road
  - Cambridge, OH 43725
  - Phone: 740-435-4200
  - Fax: 866-281-9351

- Canton
  - 400 Third St., SE
  - Canton, OH 44702-1102
  - 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: 800-821-7076
  - Fax: 866-336-8345

- Columbus
  - 30 W. Spring St.
  - Columbus, OH 43215-2256
  - Phone: 614-728-6416
  - Fax: 866-336-8352

- Dayton
  - 2401 Park Center Drive
  - Dayton, OH 45413-0910
  - Phone: 937-264-5000
  - Fax: 866-281-9356

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

- Governor’s Hill
  - 8650 Governor’s Hill Drive
  - Cincinnati, OH 45249
  - Phone: 513-563-4400
  - Fax: 866-281-9357

- Hamilton
  - 1 Renaissance Center
  - Cincinnati, OH 45011
  - Phone: 513-766-4500
  - Fax: 866-336-8343

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

- Logan
  - P.O. Box 630
  - 1225 W. Hunter St.
  - Logan, OH 43138-0630
  - Phone: 740-365-5607
  - Toll free: 800-365-5607
  - Fax: 866-336-8348

- Mansfield
  - 240 Tappan Drive, N.
  - Mansfield, OH 44906-8051
  - Phone: 419-747-4090
  - Fax: 866-336-8350

- Portsmouth
  - P.O. Box 1307
  - 1005 Fourth St.
  - Portsmouth, OH 45662-1307
  - Phone: 740-353-2187
  - Fax: 866-336-8353

- Toledo
  - P.O. Box 794
  - 1 Government Center, Suite 1136
  - Toledo, OH 43692-0794
  - Phone: 419-245-2700
  - Fax: 866-457-0594

- Youngstown
  - 242 Federal Plaza, W., Suite 200
  - Youngstown, OH 44501-1877
  - Phone: 330-797-8500
  - Toll free: 800-561-6446
  - Fax: 866-457-0596
<table>
<thead>
<tr>
<th><strong>Completion instructions (continued)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Injured worker and injury/disease/death info.</strong></td>
</tr>
<tr>
<td><strong>Last name, first name, middle initial</strong></td>
</tr>
<tr>
<td>Social Security number</td>
</tr>
<tr>
<td><strong>City</strong></td>
</tr>
<tr>
<td><strong>Wage rate</strong></td>
</tr>
<tr>
<td><strong>Date last worked</strong></td>
</tr>
<tr>
<td><strong>Date returned to work</strong></td>
</tr>
<tr>
<td><strong>State where hired</strong></td>
</tr>
<tr>
<td><strong>State where supervised</strong></td>
</tr>
<tr>
<td><strong>Description of accident</strong></td>
</tr>
<tr>
<td><strong>Type of injury/disease and part of body affected</strong></td>
</tr>
<tr>
<td><strong>Injured worker signature (injured workers only):</strong></td>
</tr>
</tbody>
</table>

**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.

**Department name:** Enter the injured worker's department or area name where he/she normally reports for work.

**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.

**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.

**Wages:** If you received wages during disability, please explain.

**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.

**Employer name:** Enter the name of the injured worker's employer at the time of the injury, occupational disease or death.

**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 injury occurred at a prior job, due to the occupational disease.

Enter this as the date of occupational disease.
Completion instructions (continued)

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.

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-OHIOBWC 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.