



INJURY REPORTING PACKET

Policy 21

CITY OF KETTERING
Safety & Health Program
Injury Reporting Packet

Responsibility for Safety

All City employees are responsible for safety.

The City Manager:

- Commits to a safe working environment consistent with requirements of applicable laws.
- Assigns the responsibility of complying with this commitment to the individual operating Department Directors.
- Assigns responsibility for coordinating required training to the Director of Human Resources.
- Assigns central record keeping to the Human Resource Department.
- Assigns the Human Resource Director the responsibility to develop and maintain a Safety Committee to coordinate mutual needs including development of safety programs.

Responsibilities of Department Directors

Department Directors are responsible for providing the support, financial resources, and overall safety leadership in the department.

- Enforcing safety rules and regulations.
- Supporting supervisors in their safety responsibilities.
- Keeping staff informed of new regulations and compliance issues.
- Assigning a safety representative (may be Director or others) to run departmental safety operation and participate on safety committee.

Responsibilities of Safety Coordinator/Executive Committee

The Safety Coordinator and the Executive Committee are responsible for facilitating the Committee's development of policies and procedures designated to enhance safety within the City of Kettering and educating employees.

The Safety Coordinator and Executive Committee are responsible for:

- Practicing and promoting safe work practices and compliance with safety regulations.
- Setting a good example for others.
- Conducting meetings at least quarterly with the Safety Committee.
- Taking immediate corrective action, as appropriate under the circumstances, for hazardous conditions that exist that would cause personal injury to staff, citizens or damage to equipment or buildings.
- Notifying the Director of Human Resources, as well as the Department Director/Manager responsible for areas in question.
- Enforcing safety regulations and City safety policy.
- Addressing hazards identified by employees.
- Making recommendations to improve the safety performance of the department.

- Supporting safety training efforts and following-up on information learned in training programs.
- Educating employees in each department/work group as to safety policies, training opportunities, and workplace hazards.

Responsibilities of Supervisors

Supervisors are responsible for ensuring work is completed in a safe manner by setting a good example, having a positive, supportive attitude toward safety and enforcing safety policies.

Supervisors are responsible for:

- Practicing and promoting safe work practices and compliance with safety regulations.
- Assuring that all operations are conducted safely.
- Assuring that all employees are trained and competent for the jobs they perform.
- Supporting safety training efforts and following-up on information learned in training programs.
- Reporting all accidents, incidents and injuries immediately in accordance with policy.
- Being alert to safety and health hazards and correcting or reporting them.
- Enforcing safety regulations and City safety policies.
- Addressing hazards identified by employees.
- Making recommendations to improve the safety performance of the department.
- Making sure employees understand the hazards of the job, necessary precautions and proper use of personal protective equipment.
- Assuring that accident reports are completed and submitted in a timely manner.

Responsibilities of All Employees

Each employee of the City of Kettering has a personal and vital responsibility to work safely and promote safety. Employees are required to perform their work in a way that will prevent injury and illness to themselves and fellow workers, and prevent property damage.

All City employees are responsible for:

- Maintaining active interest and participation in safety.
- Complying with all City safety policies and regulations.
- Reporting all accidents, incidents and injuries immediately.
- Being alert to safety and health hazards and correcting or reporting them.
- Performing all work in a safe manner.
- Operating vehicles and equipment and doing tasks only when trained and competent to do so.
- Using equipment and vehicles safely and for their intended use.
- Attending scheduled safety training programs.
- Encouraging fellow employees to work safely.
- Wearing personal protective equipment when required and when it makes good sense.
- Keeping work areas clean, orderly and free from hazards.
- Setting a good example for others.

City of Kettering – Incident or Injury Packet

Employee Instructions

Steps to take when a workplace incident or injury occurs:

Employee

1. Immediately report the incident or injury to your supervisor.
2. If medical treatment is necessary:
 - In an emergency, seek treatment at the nearest medical facility.
 - We ask that you seek medical attention from US HealthWorks, our anchor medical group. A map to their facilities is included in this packet.
 - You may seek initial treatment from any medical provider; if follow-up treatment is necessary, a Bureau of Workers' Compensation (BWC) certified provider must be used or medical bills may be your responsibility.
 - Inform your physician that the injury is work related.
 - Let your supervisor know you have received medical treatment for your work-related injury. (See Item #5 below for further details.)
3. Obtain an *Incident or Injury Packet* from your supervisor:
 - Complete the *Employee's Report of Incident and Injury (must be turned in to your supervisor within 24 hours of the injury)*. Complete all sections. If a section does not apply, please list N/A in the space.
 - If you have experienced a back injury, also complete the *Report of Back Injury* (turn in to your supervisor).
 - If medical care is required, the *BWC First Report of Injury* must be completed and turned in to your doctor who will file the form with the BWC within 24 hours of the first date of treatment.
 - The *MEDCO-14* is included as a sample of return to work instructions you will receive from the medical provider. Please submit any return to work instructions to your supervisor.
 - In the event that a prescription is necessary for the work related injury, please refer to the *Workers' Compensation Prescription and Medical Payments* instruction sheet.
4. Take your *CompManagement Health Systems Workers' Compensation Identification Card* (included in your packet) to all appointments. The card explains billing procedures for the provider and will eliminate potential billing problems.
5. Let your supervisor know that you have received medical treatment for your work-related injury and submit return to work (RTW) instructions from your doctor's visit to your supervisor. The MEDCO-14 is often used to list RTW instructions.
6. Keep your supervisor informed of the status of your work-related injury.
7. Contact Lori Skidmore, the Workers' Compensation Coordinator, if you have any questions.

Your Workers' Compensation Coordinator:

Lori Skidmore, Human Resources

Email: lori.skidmore@ketteringoh.org

Phone: 936-296-2446 • Fax: 937-296-3371

EMPLOYEE'S REPORT OF INCIDENT OR INJURY

Employee Instructions	<ul style="list-style-type: none"> This form is to be prepared by the employee within 24 hours of the incident or injury and submitted to the Immediate Supervisor & Department/Division Director. Please complete <u>ALL</u> items. Use N/A when appropriate. Attach additional page if more space is needed for any item, noting item.
Supervisor/Director Instructions	<ul style="list-style-type: none"> Please complete <u>ALL</u> items. Use N/A when appropriate. Attach additional page if more space is needed for any item, noting item. Scan or fax form to Lori Skidmore, Workers' Compensation Coordinator (lori.skidmore@ketteringoh.org or fax 937-296-3371). Send the original form by interoffice mail within 24 hours of the incident or injury.

Name _____ ☐ Male ☐ Female

Home Address _____ Birth Date _____

City/State/Zip _____ Telephone _____

Department _____ Job Title _____

Date of incident or injury _____ Time _____ ☐ a.m. ☐ p.m.

Last date worked _____ Date returned to work _____

Where did the incident or injury occur? City premises? ☐ Yes ☐ No

Exact location (Number, Street, City, Zip) _____

How did the incident occur? Be specific – name any objects or substances involved. _____

Describe what you were doing just before the incident and what you did after the incident. _____

What part(s) of your body was/were affected? (For example, right elbow, left knee, right index finger) _____

What type of injury did you experience? (For example, bruise, scrape, laceration, pull) _____

Name(s) of witness(es). Include address if not a City Employee. _____

EMPLOYEE'S REPORT OF INCIDENT OR INJURY

To whom was the incident reported? _____ Title/Position _____

Date reported _____ Time _____ ☐ a.m. ☐ p.m.

If the incident was not reported at the time it occurred, please explain why. _____

When incident occurred, were you using available safety equipment, following safety procedures? ☐ Yes ☐ No

If no, explain _____

Was medical or emergency treatment necessary? ☐ Yes ☐ No

Date of medical or emergency treatment _____

Name/address of physician or hospital _____

Did you complete/sign a Workers' Compensation Form when medical treatment was given? ☐ Yes ☐ No ☐ N/A

Is this an aggravation of a previous injury/symptom? ☐ Yes ☐ No

If yes, when were you last treated for the previous injury? _____

By whom or where were you last treated? _____

Have you ever had a similar injury? ☐ Yes ☐ No

If yes, describe other injury _____

The above statements are complete, accurate and true to the best of my knowledge:

Date

Employee's Signature

Date

Parent/Guardian Signature If Employee is under 18 years of age

MEDICAL RELEASE (Under current workers' compensation law, the employer is entitled to a signed medical release.) I hereby permit the release of medical information, records, reports, notes and memorandum relative to the disability, condition and injury described above to my employer and/or employer's representative.

Date

Employee's Signature

Date

Parent/Guardian Signature If Employee is under 18 years of age

EMPLOYEE'S REPORT OF INCIDENT OR INJURY

SUPERVISOR'S REPORT

Supervisor's Exceptions/Comments _____

Has employee ever complained of a similar disability? ☐ Yes ☐ No

If yes, state when and cause. _____

If employee was performing work to which he or she was not accustomed, state and describe nature of the work. _____

Date

Supervisor's Signature

NOTE: Signature by supervisor is verification that the supervisor has checked the validity and completeness of the statements regarding the incident or injury.

DEPARTMENT/DIVISION DIRECTOR'S REPORT

Did the employee receive proper safety instruction from the supervisor regarding operation being performed at time of incident? ☐ Yes ☐ No

Was there a safety violation? ☐ Yes ☐ No

If a safety violation was involved, please describe violation in detail. _____

Action taken to prevent a recurrence of this type of incident. _____

Date of meeting with employee and supervisor _____

Date

Department/Division Director's Signature

For Human Resource Dept. Use Only:

Reviewed by: _____

Date of Review: _____

EMPLOYEE'S REPORT OF BACK INJURY

(This form is to be completed and signed by an employee when a back injury is reported. Use reverse side of form if additional space is needed for any item, noting item.)

Employee Name _____ Job Title _____

What part of your back hurts now? _____

When did you first notice this back pain? Date _____ Time _____ ☐ a.m. ☐ p.m.

What did you feel? _____

What were you doing at that time? (Explain in detail) _____

If you were lifting an object, what was it and how heavy? _____

What was your exact position when pain was first noticed? _____

Did anyone see you get hurt? _____ Name/Title _____

Did you report/mention this injury to anyone? _____ Name/Title _____

Date Reported _____ Time _____ ☐ a.m. ☐ p.m.

If the injury was not reported at the time it occurred, please explain why. _____

Have you ever had a back injury? _____ If yes, when? _____

If yes, were you treated by a doctor? _____ Date _____

Name and address of doctor _____

Has it given you further trouble? _____

Have you ever received or filed for Workers' Compensation because of a back injury? _____

Other injury? _____

The above statements have been made by me and are true and correct to the best of my knowledge.

Date

Employee's Signature

Date

Parent/Guardian Signature if Employee is under 18 years of age

For Human Resource Dept. Use Only:

Reviewed by: _____ Date of Review: _____

Now doing business as



US HealthWorks - Huber Heights Clinic
8701 Old Troy Pike
Huber Heights, OH 45424
(937)237-6231

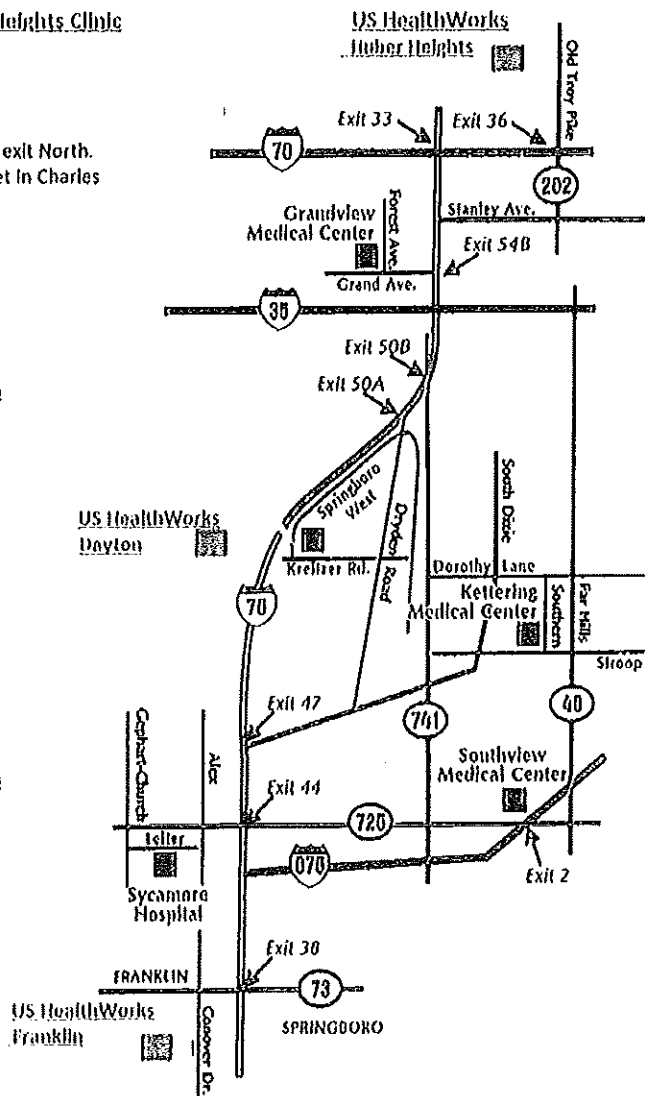
Take I-70 to SR 202 (Exit 36), exit North.
Office is on west side of street in Charles
Huber Health Center.

US HealthWorks - Dayton
2023 Springboro West
Dayton, OH 45439
(937)293-7770

Take I-75 to Dryden Rd Exit.
Turn right off exit . At the
first traffic light turn right
onto Springboro West.

US HealthWorks - Franklin
333 Conover Drive
Franklin, OH 45005
(937)746-8795

I-75 to SR 73 (exit 38)
West on SR 73 to Conover
Turn Left at traffic light onto
Conover Dr. Turn Right Into
Conover Health Center and
Immediate Right to
US HealthWorks.



Hours of Operation: Monday - Friday 8:00 AM - 5:00 PM



**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

- ❶ 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.
- ❷ Deliver, mail or fax the completed document to your employer or your employer's managed care organization (MCO).
- ❸ 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.
- ❹ 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

Dayton

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

Mansfield

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

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

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

Portsmouth

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

Cleveland

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

Cincinnati-Governor's Hill

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

Toledo

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

Columbus

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

Lima

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

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)

Last name, first name, and middle initial		Social Security number		Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Date of birth	
Home mailing address ①		City		State		ZIP code	
Wage rate Per ③		Hour ④		Month ④		Week 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.		From ④		To ④		Days of the week ④	
Occupation or job title ⑥		Employer name ⑦		Address (number and street, city or town, state, ZIP code and county)		Location, if different from mailing address	
Date of injury/disease ⑧		Time of injury ⑧		If fatal, give date of death		Time employee began work ⑨	
Date hired ⑪		State where hired ⑪		Date employer notified ⑫		State where supervised ⑬	
Description of accident: Describe the sequence of events that directly caused the injury, occupational disease or death.		⑭		⑮		⑯	
Injured worker signature ⑰		Date		Email 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



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 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Date of birth	
Home mailing address		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Number of dependents	
City		State		9-digit ZIP code		Country if different from USA	
Wage rate \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Month <input type="checkbox"/> Week <input type="checkbox"/> Year <input type="checkbox"/> Other		What days of the week do you usually work? <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thur <input type="checkbox"/> Fri <input type="checkbox"/> Sat		Regular work hours From _____ To _____		Occupation or job title	
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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain.							
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? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, give accident location, street address, city, state and ZIP code)							
Date of injury/disease		Time of injury <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		If fatal, give date of death		Time employee began work <input type="checkbox"/> a.m. <input type="checkbox"/> 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 as of information taken from me, or compensation and benefits under Ohio's workers' compensation laws for my claim, and I waive and release my right to the full and complete 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, its managed care organization and any authorized representatives. My previous or future BWC claims may affect decisions made in this claim. Proper administration of a present claim may require BWC to share claim information with the employers of record for the authorized representative(s) and/or my authorized representative for any and all such previous or future claims. The released claim information may include any recorded information 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? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Is the injury causally related to the industrial incident? <input type="checkbox"/> Yes <input type="checkbox"/> No							
E code		11-digit BWC provider number		Date			
Health-care provider signature							

Employer info.

Employer policy number		Check <input type="checkbox"/> Employer is self-insuring <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Was employee hospitalized overnight as an inpatient? <input type="checkbox"/> Yes <input type="checkbox"/> No		If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code					
<input type="checkbox"/> Certification - The employer certifies that the facts in this application are correct and valid.		<input type="checkbox"/> Rejection - The employer rejects the validity of this claim for the reason(s) listed below.		For self-insuring employers only			
				<input type="checkbox"/> Clarification - The employer clarifies and allows the claim for the condition(s) below: <input type="checkbox"/> Medical only <input type="checkbox"/> Lost time			
Employer signature and title		Date		OSHA case number			

Completion instructions (continued)

Treatment info.	Healthcare provider name	Telephone number	Fax number	Initial treatment date
	Street address	City	State	8 digit ZIP code
	Diagnosis (list. Include ICD code(s))			
	①			
	②			
Was the incident cause the injured worker to miss eight or more days of work? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is the injury causally related to the industrial incident? <input type="checkbox"/> Yes <input type="checkbox"/> No		
E code ③		11 digit BWC provider number ④ Date		
Health care provider's signature ⑤				

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 Employer policy number	④	<input type="checkbox"/> Employer is self-insuring
	Telephone number	Fax number	<input type="checkbox"/> Injured worker is owner/partner/member of firm
	City	State	ZIP code
	Was employee treated in an emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was employee hospitalized as an inpatient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code		
<input type="checkbox"/> Certification - The employer certifies that the facts in this application are correct and valid.		<input type="checkbox"/> Rejection - The employer rejects the validity of this claim for the reason(s) listed below.	
Employer's signature and title		Date OSHA case number ⑥	

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.



This form provides important information about the injured worker's ability to work.

- The treating physician must submit this form each time he/she sees the injured worker unless the injured worker has been awarded permanent and total disability, has returned to work without restrictions within seven days of the injury, or is being treated after the treating physician has released him/her to his/her former position without restrictions.
- Please complete this form and provide a copy to the injured worker during his/her office visit. Fax a copy to the appropriate managed care organization (MCO) or to the injured worker's employer if self-insured.
- This form or an equivalent physician-generated document may support a request for temporary total compensation. The equivalent document must contain, at a minimum, the data elements required on this form. If you have submitted previously equivalent data elements that remain the same, indicate the name of the report that reflects the injured worker's current condition, e.g., May 15, 2015, office note.
- You may attach additional medical documentation such as diagnostic test results and a treatment plan to this form.
- Failure to provide complete detailed information may delay or suspend compensation payments to the injured worker.

Instructions

MEDCO-14 submission section: You must select only one of the three choices by selecting the appropriate box. If you previously completed a MEDCO-14 and there are changes, you must indicate the changes in the appropriate section on the form, and select the yes box in that section. For all other sections, you would make no entry, and select the no box.

Employment/occupation section: Please indicate if you have reviewed a description of the injured worker's job held on the date of the injury. Please indicate all sources providing you a description of the injured worker's job. If you do not have a copy of the injured worker's job description, BWC or the MCO can help secure one.

Work status/Injured worker's capabilities section: Please complete this section as accurately and thoroughly as possible, as BWC will use this information to understand the injured worker's work status and help facilitate his/her appropriate and safe return to work either to his/her job held on the date of injury or an alternative job if he/she cannot return to the job held on the date of injury.

3A: Please indicate if the injured worker has any physical or health restrictions related only to the allowed conditions in the claim. If there are restrictions, please indicate if the restrictions are permanent or temporary. If there are no related restrictions you should check the release to work box. The date of the exam will be the release to work date.

3B: If there are restrictions related only to the allowed conditions in the claim, indicate whether or not the injured worker can return to the full duties of his/her job held on the date of injury. If you determine the injured worker cannot return to the full duties of his/her job held on the date of the injury, you must include the date for which you indicate the injured worker could not fully perform the duties of his/her job held on the date of the injury. You must also indicate an estimated date when you believe the injured worker should be able to fully perform the duties of the job held on the date of injury. It is imperative that you follow all 3B instructions. This will facilitate appropriate processing of the injured worker's claim. Updates to dates in 3B requires 4A to be completed.

3C: Although an injured worker may not be able to fully return to the job held on the date of injury, understanding the injured worker's capabilities will assist in identifying appropriate and safe work that an injured worker may be able to perform. If an injured worker may return to available and appropriate work with restrictions accommodated, please indicate the possible return to work date. Further, to facilitate BWC's efforts to safely return an injured worker to appropriate work, indicate which of the activities listed in this section, the injured worker can perform. The following definitions apply to the section on Lifting/carrying, Pushing/pulling and Activity with the percentages reflected as they relate to an eight-hour workday:

- Never – 0 percent;
- Occasionally – 1 percent to 33 percent, four to six repetitions per hour;
- Frequently – 34 percent to 66 percent, six to 12 repetitions per hour;
- Continuously – 67 percent to 100 percent, greater than 12 repetitions per hour.

Please note that if the "yes" box is checked in response to the question of whether the injured worker has functional restrictions based only on allowed psychological conditions the MEDCO-16 should be referenced as needed.

We encourage you, in the space provided, to provide any additional information you believe would benefit the injured worker's safety and care relative to any return to work considerations.



Instructions continued

4A: Disability period information section: It is critical that if you answered No to 3B or made changes to dates in 3B this section is fully completed: Please furnish the narrative description of the diagnosis(es), site/location and International Classification of Diseases code for only allowed conditions being treated. You must indicate by checking the appropriate box whether the allowed condition is preventing the injured worker from returning to the job held on the date of injury.

4B: In this area you should list all other relevant conditions that impact treatment of the allowed conditions in the claim.

Clinical findings section: Provide medical rationale for the delay in the injured worker's recovery and the barriers to return to work.

Maximum medical improvement (MMI) section: Provide the MMI date or explain why the injured worker has not reached MMI. Provide the proposed treatment plan, including estimated duration.

Vocational rehabilitation section: If the injured worker is not a candidate for vocational rehabilitation, explain and recommend actions to help the injured worker return to employment.

Treating physician's signature section: Sign and date this form. Your signature indicates you have answered the questions as truthfully and completely as possible.

For more information or assistance

Please contact your local BWC customer service office, or call 1-800-644-6292. You can obtain BWC forms at www.bwc.ohio.gov, at all BWC customer service offices, or by calling 1-800-644-6292 and listening to the options to reach a BWC customer service representative.



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 <input type="checkbox"/> I have never completed a MEDCO-14. <i>Proceed to section 2.</i> <input type="checkbox"/> I have previously completed a MEDCO-14, and all of the information remains the same. <i>Proceed to and complete section 8.</i> <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>)				
2 Have you reviewed the description of the injured worker's job held on the date of injury (former position of employment)? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes - please indicate who (select all sources) provided the job description <input type="checkbox"/> Injured worker <input type="checkbox"/> Employer <input type="checkbox"/> MCO <input type="checkbox"/> BWC											
Work status/Injured worker's capabilities							(Updates Yes <input type="checkbox"/> No <input type="checkbox"/>)				
3A Does the injured worker have any physical or health restrictions related to allowed conditions in the claim? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, are the restrictions: <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary <i>Proceed to section 3B.</i> If no, please check the box to indicate the injured worker is released to work as of the date of this exam. <input type="checkbox"/> <i>Proceed to section 8.</i>											
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 <input type="checkbox"/> No <input type="checkbox"/> If yes, please check the box to indicate that the injured worker is released to work as of the date of this exam. <input type="checkbox"/> <i>Proceed to section 8.</i> 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: _____ <i>Proceed to section 3C.</i>											
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: <input type="checkbox"/> Left hand <input type="checkbox"/> Right hand <input type="checkbox"/> Both The injured worker can perform repetitive wrist motion with: <input type="checkbox"/> Left hand <input type="checkbox"/> Right hand <input type="checkbox"/> Both The injured worker's dominant hand is: <input type="checkbox"/> Left <input type="checkbox"/> Right The injured worker can perform repetitive actions to operate foot controls or motor vehicles with: <input type="checkbox"/> Left foot <input type="checkbox"/> Right foot <input type="checkbox"/> Both If the injured worker is taking prescribed medications for the allowed conditions in this claim, can the injured worker safely: *Operate heavy machinery: <input type="checkbox"/> Yes <input type="checkbox"/> No *Drive: <input type="checkbox"/> Yes <input type="checkbox"/> No *Perform other critical job tasks as defined by any source listed above in section 2: <input type="checkbox"/> Yes <input type="checkbox"/> No											
Please indicate the following: N = Never, O = Occasionally, F = Frequently, C = Continuously											
Activity		N	O	F	C	Activity		N	O	F	C
Bend		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reach above shoulder		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat/kneel		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type/keyboard		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twist/turn		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work with cold substances		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work with hot substances		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting/carrying		N	O	F	C	Pushing/pulling		N	O	F	C
0 - 10 lbs.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	0 to 25 lbs.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 - 20 lbs.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	26 to 40 lbs.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21 - 40 lbs.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	41 to 60 lbs.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41 - 60 lbs.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	61 to 100 lbs.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
61 - 100 lbs.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	100 + lbs.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3C 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 <input type="checkbox"/> Continuously <input type="checkbox"/> With break Walk: _____ hours <input type="checkbox"/> Continuously <input type="checkbox"/> With break Stand: _____ hours <input type="checkbox"/> Continuously <input type="checkbox"/> With break Does the injured worker have any functional restrictions based only on allowed psychological conditions? <input type="checkbox"/> Yes <input type="checkbox"/> 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.											

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 <input type="checkbox"/> No <input type="checkbox"/>)
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 <input type="checkbox"/> No <input type="checkbox"/>	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
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 <input type="checkbox"/> No <input type="checkbox"/>)
5	The injured worker is progressing: <input type="checkbox"/> As expected <input type="checkbox"/> Better than expected <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>)
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 <input type="checkbox"/> No <input type="checkbox"/> If yes, give MMI date: _____. If no, please provide the proposed treatment plan, including estimated duration of each treatment (attach additional sheet if necessary).				
<small>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.</small>					
Vocational rehabilitation					(Updates Yes <input type="checkbox"/> No <input type="checkbox"/>)
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 <input type="checkbox"/> No <input type="checkbox"/> 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	

Workers' Compensation Prescription and Medical Payments

Prescriptions

- After your claim is allowed, give your prescription with your claim number to any BWC-certified pharmacy. They will bill BWC's Pharmacy Benefits Manager (PBM) directly, and you will have no deductible or co-pay on allowed medications in your claim.
- A pharmacy can fill a 10-day supply of your first prescription before the claim is allowed or has a BWC claim number. The pharmacy should use your Social Security number, date of injury and write "for work-related injury" on the script.
- If you have paid for a prescription and need to be reimbursed, you have two options.
 1. After your claim is allowed, ask your pharmacist to resubmit the prescription to BWC's PBM. The PBM will pay the pharmacy the allowed amount for the prescription, and the pharmacy will reimburse you.
 2. File a Request for Injured Worker Outpatient Medication Reimbursement (C-17). Attach prescription labels with pricing information and mail to address listed on the C-17 form.

Medical bills

Give your claim number to all of your medical providers who treat you for the allowed conditions in your claim. You should receive a BWC ID card that lists your claim number and managed care organization (MCO) contact information. The medical provider will request authorization for all medical treatment from the MCO assigned to your claim and listed on your ID card. (The City's MCO is CompManagement Health Systems.)

Take your CompManagement Health Systems Workers' Compensation Identification Card (included in your packet) to all appointments. The card explains billing procedures for the provider and will eliminate potential billing problems.

Surgery and diagnostic tests

Your treating medical doctor, or physician of record, will submit a Physician's Request for Medical Service or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease (C-9) to the assigned MCO for pre-authorization of surgeries or diagnostic tests for the allowed conditions in the claim.

Medical bills for additional conditions

Sometimes the treating medical doctor will need BWC to add an additional condition to the claim before the MCO can authorize additional treatment. The medical bill for the treatment for the additional condition cannot be paid until the additional condition is allowed in the claim.

If BWC disallows the claim, bills become the injured worker's responsibility.



Workers' Compensation Identification Card

1 (888) 247-7799 Customer Service
1 (888) 247-4800 Injury Report Number

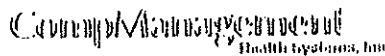
State Insured Employer
CITY OF KETTERING
35705702-0



Prescription questions: contact the
Pharmacy Benefits Manager at 1 (800) 644-6292
press 0, select option 3, then select option 2.

Employer has alternate duty program that accommodates restrictions.
Fax all information within 24 hours of visit to 1 (800) 334-4229
or (614) 718-9870.

Send bills to:
CompManagement Health Systems, Inc.
Attn: Billing Dept.
P.O. Box 1040
Dublin, Ohio 43017



CompManagement Health Systems, Inc. provides administrative services
and network access only and does not assume any financial risk or
obligation with respect to claims.

This card does not guarantee claim approval.

The City Manager hereby delegates the appropriate responsibility and authority to administer this policy to the Department Directors.

Approved:

4-26-18
Date


Mark Schwieterman
City Manager

Issued:

4-26-18
Date


Sara E. Mills Klein
Director of Human Resources

— Reviewed 05/18.