



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.

Form section for injured worker and injury/disease/death info. Includes fields for: Last name, first name, middle initial; Social Security number; Marital status; Date of birth; Home mailing address; Sex; Number of dependents; City; State; 9-digit ZIP code; Country if different from USA; Department name; Wage rate; What days of the week do you usually work?; Regular work hours; 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?; Occupation or job title; Employer name (DIOCESE OF CLEVELAND); Mailing address; Location; Was the place of accident or exposure on employer's premises?; Date of injury/disease; Time of injury; If fatal, give date of death; Time employee began work; Date last worked; Date returned to work; Date hired; State where hired; Date employer notified; State where supervised; Description of accident; Type of injury/disease and part(s) of body affected.

Treatment info.

Form section for treatment info. Includes fields for: Health-care provider name; Telephone number; Fax number; Initial treatment date; Street address; City; State; 9-digit ZIP code; Diagnosis(es); Will the incident cause the injured worker to miss eight or more days of work?; Is the injury causally related to the industrial incident?; E code; 11-digit BWC provider number; Date; Health-care provider signature.

Employer info.

Form section for employer info. Includes fields for: Employer policy number (20003507); Check if Employer is self-insuring; Telephone number (216-731-8215); Fax number (216-731-8290); E-mail address; Federal ID number; Manual number; Was employee treated in an emergency room?; Was employee hospitalized overnight as an inpatient?; If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code; Certification/Rejection/Clarification options; Employer signature and title; Date; OSHA case number.