

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;

WARNING:

Any person who obtains compensation from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false $statements\,oraccepting\,compensation\,to\,which\,he$ or she is not entitled, is subject to felony criminal

Learner, metal rearve, middle initial Social Sequity number Social Sequi		omminitian inave not received compensation and/or benefits under the workers' compensation haves 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.								prosecution for fraud. (R.C. 2913.48)				
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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 policy number 80105032000 Employer is self-insuring Injured worker is owner/partner/member of firm Manual number Fax number E-mail address Federal ID number Manual number Manual number If reatment 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: Medical only Lost time Lost ti		Health-care provider name					elephone numb	Fax number		Initial treatment date				
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Health-care provider signature Employer policy number Employer is self-insuring Injured worker is owner/partner/member of firm Telephone number Fax number E-mail address Federal ID number Manual 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: Medical only Lost time Lost time	ළ		the injury caus											
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Telephone 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: Medical only Lost time Manual number Manual number Manual number	\geq	= 1 7 1 - 7												
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