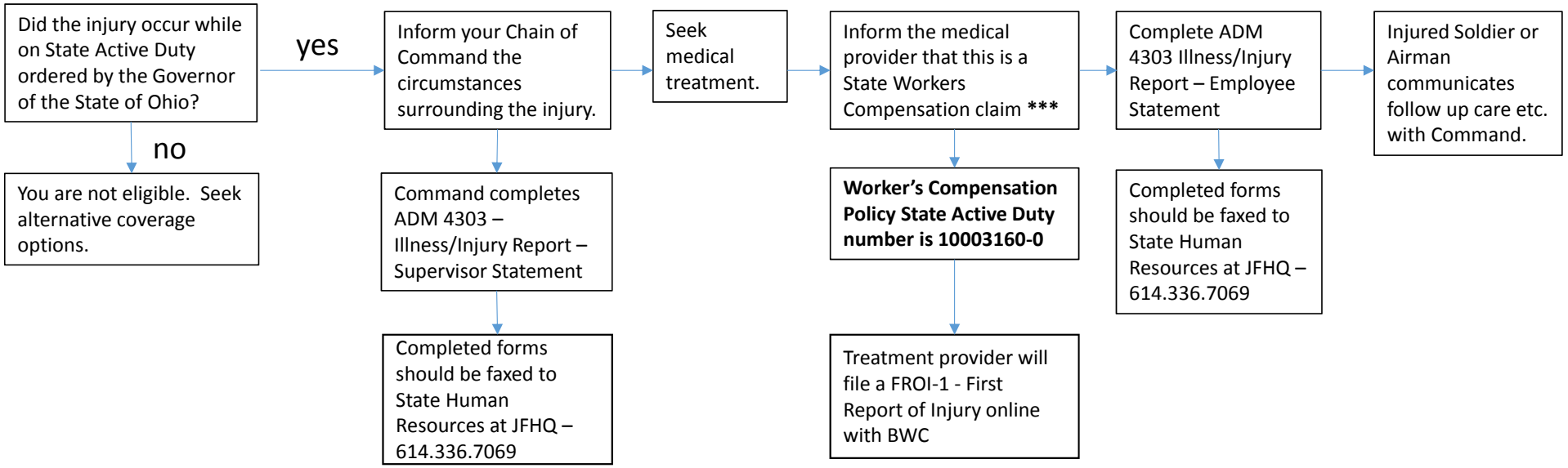
Worker's Compensation Process Flow for State Active Duty Injuries ONLY



* Approximately 2 weeks after the accident you will receive a letter from Worker's Compensation with your claim number. If you do not receive anything please immediately contact State HR 614-336-7151 so we can help timely resolve any issues.

*** Do not give the medical provider your Tri-Care card or your personal health insurance card.

Rev 7/16

Employee Instructions for completing the ADM 4303 Injury / Illness Report

This form **must be completed** as part of the Workers' Compensation application process. Failure to fully complete this report may result in the denial or delay of benefits. Write legibly with a black or blue ink pen (do not use pencil) or file electronically.

IMPORTANT NOTICE: 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)

Employee Statement
The injured employee is responsible for completing the following sections:

Personal Information- Please fully complete all requested information.

Incident report Information
You must:
- Follow your specific agency's incident reporting procedures
- Provide the exact date and time the incident occurred
- Provide the exact date and time the incident was reported
- List to whom (name, title and phone #) you reported the accident / incident

Off Work Benefits – you must make a selection, refer to your specific bargaining unit contract for details. *You **cannot** collect temporary total compensation and salary continuation or OIL benefits for the same period time.*

- ***Temporary Total Compensation (TT)*** – TT benefits are paid by BWC. Your injury must result in eight (8) or more calendar days of lost time from work before TT is considered. Please refer to www.bwc.ohio.gov for specific details.

- *** ***Salary Continuation (SC)*** – SC are benefits paid by your employer and equal to your total rate of pay not to exceed 480 hours per workers' compensation claim. SC is effective the date of the injury and does not require a waiting period.

- *** ***Occupational Injury Leave (OIL)*** – OIL are benefits paid by your employer and equal to your total rate of pay not to exceed 960 hours per workers' compensation claim. An employee who incurs a work-related injury or illness inflicted by a ward of the State (inmate, patient, resident, client, youth or student) may be entitled to OIL. Refer to your specific bargaining unit contract for details, as OIL applies to certain agencies.

WILMAPC PROVIDER

*** **IF YOU ARE INJURED ON THE JOB AND WANT TO RECEIVE SALARY CONTINUATION OR OCCUPATIONAL INJURY LEAVE, YOU MUST SEEK MEDICAL TREATMENT FROM A PHYSICIAN ON THE WILMAPC APPROVED PROVIDER LIST AND MEET ALL QUALIFICATIONS AS STATED IN THE UNION CONTRACT OR AGENCY POLCIY.**

YOU MAY CONTACT YOUR MCO REPRESENTATIVE OR ACCESS THE WILMAPC PROVIDER LIST AT:

http://www.das.ohio.gov/wilmapc

Employee Incident Description
You must explain in DETAIL how you were injured, including
- What caused the injury/illness, where the incident occurred, how the incident occurred, explain what you were doing at the time of the incident, include the ACTUAL SPECIFIC location where the incident occurred and list any witnesses to the incident
- Indicate the body part affected and the illness or injury that resulted from the incident

Injured Worker Signature/Date
Please read and complete this form in its entirety. Be sure to date and sign it before returning it to your employing agency designee/personnel officer.

NOTICE: "The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information", as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."

Physician statement
Please have your health-care provider complete the bottom portion of the form when you seek outside medical treatment. This section must be completed in its entirety.

Injury / Illness Report

Employee Statement *(completed by employee)*

Check all that apply:

- ____ Full time Employee
- ____ Part-time Employee
- ____ Interim Employee
- ____ Exempt
- ____ Seasonal / temp
- ✔ Other: ADJ- SAD
- ____ OCSEA *Unit* _____
- ____ FOP Unit 2
- ____ 1199
- ____ ORC 124.381
- ____ ORC 124.15
- ____ OSTA
- ____ Other: _____

PERSONAL INFORMATION

Employee's full name:

Address (Street / City / State / Zip):

Social Security #:

Phone # (Home / Work):

Date of Birth:

Age:

Sex:

Your employer's name: Adjutant General's Dept - SAD

Job Title/Department:

Employer's BWC Policy #: 1003160-0

Regular work hours: From _____ am/pm To _____ am/pm

Work Days: ___Sun ___Mon ___Tues ___Weds ___Thurs ___Fri ___Sat

INCIDENT REPORT INFORMATION

Date/Time of Injury:

Were you working overtime when this injury occurred? ____ Yes ____ No

Reported to (Name/Title):

Date/Time Reported:

OFF WORK BENEFITS:

Check one benefit type:

- ____ Temporary Total Compensation
- ____ Salary Continuation*
- ____ Occupational Injury Leave* (see instructions page)

***Must seek medical treatment from WILMAPC approved provider** http://www.das.ohio.gov/wilmapc

Exact location of incident (Include name of building/area and location within building/area or town, county, State Route or mile marker):

Were there any witnesses? Please list names:

Are you working, in any capacity, for another employer: ____Yes ____ No If yes, employer name:

EMPLOYEE INCIDENT DESCRIPTION (Please DESCRIBE how the injury happened in DETAIL)

What duties were you performing?

What caused the injury? (e.g. I slipped on the ice.)

Indicate body part(s) affected (for example: left knee sprain):

Benefit application release of information / medical release – I am applying for a claim under the Ohio Workers' Compensation Act for work-related injuries that I did not purposely inflict. I affirm that I elect to receive 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, Ohio Job and Family Services, and Opportunities for Ohioans w/Disabilities to release medical, psychological, psychiatric, pharmaceutical, vocational and social information. I understand this may include personally identifying information that is causally 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, DAS, employing agency, the employer's BWC MCO and their 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 employer of record (or its 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. I have read and understand the information described on the ADM4303 instructions page. A photocopy of this authorization shall be as valid as the original.

Employee Signature:

Date:

PHYSICIAN'S STATEMENT (Take to your health-care provider to complete)

Health-care provider name (please print):

Initial treatment date:

Telephone number: ( ) -

Fax number: ( ) -

Street address, city, State, 9-digit ZIP code:

Diagnosis(es): Include ICD code(s):

Will the incident cause the worker to miss 8 or more days from work? ____Yes ____ No

Is the injury causally related to the industrial incident? ____Yes ____ No

E code:

11-digit BWC provider #:

Health-care provider signature and date:

Injury / Illness Report
Employer Statement *(completed by WC designee)*

Date rec'd by personnel:

BWC claim # and/or injury date:

Date and time reported to supervisor:

BWC Policy #: 10003160-0

Work County:

EMPLOYER INFORMATION

Employee's Name:

Agency (Specify operating location or Central Office): Adjutant General's Dept - SAD

Address (Street / City / State / Zip): 2825 W. Dublin Granville Rd., Columbus, Ohio 43235

Did this injury occur on employer premises? ____ YES If NO, include address of where injury occurred:

Hire date:

Employment type: ____ PT ____ FT ____ Interim ____ Temp

Bargaining Unit Status: OCSEA Unit ____ FOP ____ 1199 ____ Exempt ____ Other: State Active Duty

Did employee seek nursing/first aid care? ____ Yes ____ No

If yes, from?

Was the employee off work eight (8) or more calendar days? ____ Yes ____ No

Did employee use sick leave, vacation leave, personal leave, or any other leave with pay for any of the lost work days? ____ Yes ____ No

If yes, have you attached a calendar of wages showing leave usage? ____ Yes ____ No

Employee has applied for payment under:
____ Salary Continuation ____ OIL
____ WC-TTD ____ Disability benefits
Other:

Has the employee returned to work? ____ **Yes** ____ **No**

If YES, provide **the ACTUAL DATE:**

If NO, provide an estimated RTW **DATE**:

What was the last **date** the employee worked?
DATE:

Indicate (check) whether this was a full duty return ____
OR a transitional duty return ____

Was a Transitional Work Assignment offered to this employee? ____ Yes ____ No

Is a Position Description and / or Job Analysis attached? ____ Yes ____ No

Did this injury result in a fatality? ____ Yes ____ No

If yes, give date of death:

Date faxed/reported to MCO:

By whom:

SC or OIL BENEFITS: *(Check if applicable) A completed calendar of wages must be submitted if SC or OIL is requested*

____ **SALARY CONTINUATION**

____ **OCCUPATIONAL INJURY LEAVE**

OIL - Do you believe this is a legitimate OIL injury? ___ Yes ___ No

Appointing Authority Signature: _____

Date employee became disabled:

Date: Coordinator's initials:

Total hours being requested:

Comments:

Treating with an approved WILMAPC physician? __Yes __No

EMPLOYER CLAIM CONTACT (please print clearly)

Name Title Phone#

EMPLOYER CLAIM POSITION (check applicable section)

____ CERTIFICATION

Based on the information known at this time the employer CERTIFIES that the facts in this application are correct and valid. This certification does not waive any appeal rights that may exist if the employer so chooses to exercise those rights.

____ UNKNOWN

This claim is still in process and pending further investigation and claim research.

____ REJECTION

The employer rejects the claim for the following reason(s):

Employer signature Date

Injury / Illness Report

Supplemental Statement *(completed by Supervisor and Safety & Health Coordinator)*

Employee Name: _____

BWC Claim #: _____

Supervisor Statement *(to be completed by the Supervisor)*

Date Injury reported to supervisor:	Time Injury reported to supervisor:
Contributing weather or environmental factors:	Any equipment involved? _____ Yes _____ No If yes, please specify:

Was the employee performing his/her regular job duties? _____ Yes _____ No

If No, please explain:

Specific action taken to avoid another injury:

Will disciplinary action be initiated? _____ Yes _____ No

Please explain:

Supervisor full name:	Work phone #:	
Job title:	Regular shift:	Days off:
Supervisor's signature:		Date:

Safety & Health Statement *(to be completed by the S&H Coordinator)*

Fully describe the incident (What occurred, what was the injury type, what object directly harmed the employee?):

What was the employee doing immediately before the incident?:

What conclusions can be drawn?:

Comments and/or recommendations to improve safety:

S & H Coordinator full name:	Work phone #:	
Job title:	Regular shift:	Days off:
S & H Coordinator's signature:		Date: