Ohio | Bureau of Workers' Compensation

# First Report of Injury, Occupational Disease, or Death (FROI)

Submit the form to BWC in one of the following ways. **Online:** www.bwc.ohio.gov, **Fax:** 1-866-336-8352, **Mail:** BWC Mail Processing Center, Attn: Claims, 30 W. Spring St. Columbus, OH 43215
**Note:** If you work for a self-insuring employer, submit this form to your employer's workers' comp manager.

## Injured worker information

| First name, middle initial, last name | Date of injury/disease | Social Security number | Date of birth |
|---|---|---|---|
| | | | |

| Mailing address; add apartment number or P.O. Box, if applicable | City | State | ZIP code |
|---|---|---|---|
| | | | |

| Sex ☐ Male ☐ Female | Email address | Home phone number | Cell phone number |
|---|---|---|---|
| | | | |

| Employer name | Employer address | City | State | ZIP code |
|---|---|---|---|---|
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| Was the injured worker hired through a temp agency? ☐ Yes ☐ No<br>If yes, name of temp agency | Mark the days of the week you usually work<br>☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat | Regular work hours (include a.m. p.m.)<br>From To |
|---|---|---|
| | | |

| Date hired | Job title | State where hired | State where supervised | Wage rate; $ per hour | Number of hours scheduled to work the week of this injury |
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| Work number for call-offs (Number injured worker calls to reach supervisor) | Part(s) of body affected (For example: Left knee, right index finger) |
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| Accident description (Describe the sequence of events that directly caused the injury or death.) | **Will the incident cause the injured worker to miss 8 or more days from work?** ☐ Yes ☐ No |
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| Injured worker start time<br>_____ ☐ am ☐ pm | Time of injury<br>_____ ☐ am ☐ pm | Date employer notified | Was any part of a workday missed due to the injury? ☐ Yes ☐ No | Date last worked | If the injured worker has returned to work, provide the date. |
|---|---|---|---|---|---|
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| Was the place of the accident or exposure on employer's premises? ☐ Yes ☐ No If no, give accident location, street address, city, state, and ZIP code. | Was injured worker hospitalized overnight?<br>☐ Yes ☐ No |
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| Initial treatment date | Health-care office/Facility name | Treating physician/Provider name | Telephone number | Fax number |
|---|---|---|---|---|
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| Health-care office/Facility street address | City | State | ZIP code |
|---|---|---|---|
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**If the injury resulted in death, answer the following.**

Date of death Decedent's marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Decedent's number of dependents

## To be completed by the injured worker

**By signing this form, I:**

- **Elect to only receive compensation, benefits, or both provided for in this claim under Ohio's workers' compensation laws.**
- **Understand, waive, and release my right to receive compensation and benefits under the workers' compensation laws of another state for the injury, occupational disease, or death resulting from an injury or occupational disease for which I am filing this claim.**
- **Confirm I have not received compensation and benefits under the workers' compensation laws of another state for this claim, and I will notify BWC immediately upon receiving any compensation or benefits from any source for this claim.**
- **Will not file and have not filed a claim in another state for the injury, occupational disease, or death resulting from an injury or occupational disease for which I am filing this claim.**

**Furthermore, I understand that:**

- Upon request, my treating providers may submit to BWC, my employer, my employer's managed care organization or qualified health plan, or their authorized representatives medical, psychological, psychiatric, or vocational documentation relating causally or historically to physical or mental injuries relevant to this claim and necessary for me to obtain medical services, benefits, or compensation.
- Proper administration of this claim may require BWC to review and share with the employers of record, their authorized representatives, or my authorized representative any information or record maintained in this claim, or in my previous or future claims.
- Information or records maintained in my previous or future claims may affect decisions made in this claim.
- Any person who obtains compensation or benefits from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false statements, or accepting compensation or benefits to which he or she is not entitled, is subject to felony criminal prosecution for fraud (Ohio Revised Code 2913.48).

I certify that I have read, understand, and agree to the above statements and the information contained on this form is true and accurate to the best of my knowledge.

| Injured worker signature | Date |
|---|---|
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## To be completed by the treating provider

Diagnosis(es)-narrative description including as appropriate, the location and body part, and ICD code(s). **Important:** If there is an injury, list the condition or disease, not the symptoms or exposure. For example, "sprain right knee" not "pain right knee", "toxic effect of ammonia" not "exposure to ammonia", "contusion to the head" not "headache".

| Initial treatment date | Are the medical conditions you have listed above causally related to the reported work-related accident or occupational disease? ☐ Yes ☐ No<br>Are you the physician of record? ☐ Yes ☐ No |
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| Treating physician/Provider's name (Print) | Treating physician/Provider's signature | BWC provider number | Date |
|---|---|---|---|
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## To be completed by the employer

| Employer name | Employer county | Phone number | Fax number | Email address |
|---|---|---|---|---|
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| Employer policy number | Federal ID number | Injured worker is (Check box, if applicable.) ☐ Owner/Sole proprietor ☐ Partner ☐ Individual incorporated as a corporation |
|---|---|---|
| | | |

**For all employers:** ☐ Certification – I certify the facts in this application are correct and valid. ☐ Rejection – I reject the validity of this claim for the reason(s) listed below.

**For self-insuring employers only:** ☐ Medical only ☐ Lost time

Clarification – I clarify and allow the claim for the condition(s) below.

| Employer signature and title | Date |
|---|---|
| | |

## To be completed by the submitter if the form is completed by someone other than the injured worker, treating physician, or employer

| Signature of person completing this form | Date |
|---|---|
| | |