Self-Insured Injury Reporting PACKET

Self-Insured Injury Reporting PACKET

OHIO UNIVERSITY

CareWorks Consultants Inc.
A York Risk Services Company
IMPORTANT NOTICE FOR WORKPLACE INJURIES

In the event of a work-related injury, please see one of the medical providers recommended by your employer listed below and follow these important steps:

1. Report the accident immediately to your supervisor.
2. Select a medical provider from the following list for immediate care.*
3. For additional providers, call CareWorks Consultants 1-800-837-3200 from 8:00-5:00.

In the event of a life threatening injury, seek the closest hospital emergency room regardless of physician network affiliation or BWC certification status.

PROVIDER LISTINGS FOR WORKERS’ COMPENSATION

OCCUPATIONAL HEALTH

OhioHealth WorkHealth - Athens
(Located within the Castrop Health Center)
75 Hospital Drive, Suite 370
Athens, Ohio 45701
(740) 331-7060
Hours of Operation:
Monday - Friday, 7:00 a.m. - 4:00 p.m.

University Medical Associates (UMA)
265 West Union Street, Suite A
Athens, Ohio 45701
(740) 594-2456
Hours of Operation:
Monday - Friday, 9:00 a.m. - 6:00 p.m.
Weekends, 10:00 a.m. - 6:00 p.m.

HOSPITAL

O’Bleness Hospital
55 Hospital Drive
Athens, Ohio 45701
(740) 593-5551

*Employees may receive treatment from any BWC certified provider.
Ohio University has selected CareWorks Consultants to manage its workers’ compensation medical benefits. If injured at work, please follow these important steps:

1. Complete an Ohio University Incident Report Form and an Ohio Bureau of Workers’ Compensation’s First Report of Injury (FROI) form and submit to the Human Resources Department within 24 hours of your workplace injury. **You can fax these forms to (740) 597-1993.**

2. Show this card to every medical provider that treats your workplace injury.
Ohio University
BWC Self-Insured Policy # 20005755-0

Human Resources Department Contacts:
Larry Wines @ (740) 597-1992
Marilyn McVey @ (740) 597-1994

Attention Provider: Please notify CareWorks Consultants Inc. at 1-800-837-3200 for pre-admission certification and prior authorization. All care to be based on workers’ compensation treatment guidelines.

Billing Address (for all non-pharmacy bills): CareWorks Consultants, Inc.
P.O. Box 8101 Dublin, Ohio 43016 1-800-837-3200 | Fax: (614) 764-7629

Attention Employee: This card may be used for conditions in your workers’ compensation claim and is not a guarantee of coverage.

Pharmacy Benefits: Call Modern Medical at 1-800-547-3330.
What to do in the event of an injury while working at Ohio University.

What happens when my physician releases me to work?
Ohio University’s Human Resources Department and the CareWorks Consultants medical case manager will make every effort to help you return to your job as soon as possible. Ohio University will help your physician return you to light duty work or a transitional work program if there are restrictions on your activity that prevent you from performing your regular job duties.

Why does Ohio University investigate the accidents?
One way to prevent future accidents is to learn more about your workplace injury. After a complete investigation, your manager or supervisor may be able to make meaningful changes, reducing the chance that another employee will be injured in the same manner.

Who do I call if I have questions?
Contact Ohio University’s Human Resources Department’s Larry Wines at (740) 597-1992 or Marilyn McVey at (740) 597-1994. Any questions concerning physician visits, change of physician or medical treatment requests can be directed to your medical case manager at 1-800-837-3200.

What if I am not satisfied with the medical treatment I am getting from my doctor?
If you are dissatisfied with your doctor, we encourage you to talk to the Human Resources Department or your CareWorks Consultants medical case manager. We will work with your treating physician on an appropriate treatment plan or, if necessary, we will assist you in finding another doctor with whom you are more comfortable. You ultimately have the freedom to choose any licensed physician who will accept workers’ compensation injuries.

What should I do if medical bills are sent to me?
If you receive bills from your doctor or the hospital, please send them to:
CareWorks Consultants, Inc.
P.O. Box 8101
Dublin, Ohio 43016
OHIO UNIVERSITY’S GOAL IS TO PROVIDE A SAFE WORK ENVIRONMENT DESIGNED TO PREVENT WORKPLACE INJURIES. HOWEVER, SHOULD YOU SUSTAIN A WORKPLACE INJURY, THE FOLLOWING ARE ANSWERS TO TYPICAL QUESTIONS YOU MAY HAVE ABOUT YOUR ON-THE-JOB INJURY.

REPORT ALL INJURIES TO YOUR SUPERVISOR IMMEDIATELY!

What if I need more than First-Aid?
All accidents should be reported to your manager/supervisor immediately, regardless of the level of medical treatment you need. You will be asked to complete an Ohio University Incident Report Form and an Ohio Bureau of Workers’ Compensation’s (BWC’s) First Report of Injury (FROI) form. Please submit these two forms to the Human Resources Department within 24 hours of your workplace injury to start your workers’ compensation claim. Both forms are included in this packet.

In emergency situations, you should seek immediate medical attention and complete these forms as quickly as you are able.

In non-emergency situations, you may seek medical treatment from a licensed provider of your choosing or you may call the Human Resources Department’s Larry Wines at (740) 597-1992 or Marilyn McVey at (740) 597-1994, or your CareWorks Consultants nurse at 1-800-837-3200 to identify quality licensed providers in your area.

What happens to the First Report of Injury (FROI) form that I fill out with my physician?
The Human Resources Department will keep a copy of your FROI form for your workers’ compensation file. The FROI will also be sent to CareWorks Consultants so they may process your claim. In some instances, CareWorks Consultants will also file a copy of the FROI with the Ohio Bureau of Workers’ Compensation (BWC).

Who will pay for my Doctor’s bills?
As a self-insured employer, Ohio University will pay for authorized physician visits and related treatments if the injury was caused by an on-the-job accident. CareWorks Consultants will issue payment for appropriate medical treatment directly to your physician on behalf of Ohio University.

How do I get my prescriptions filled?
This injury packet contains a Modern Medical instant access card that will allow you to get a first fill on your initial prescription. First fill services are provided through the Modern Medical Prescription program. If you require refills or additional medication for an allowed work-related injury, you will receive additional information in the mail from Modern Medical. Additional information on how the prescription program works is available through CareWorks Consultants.

What happens if I cannot return to work?
The Ohio University’s Human Resources Department and your CareWorks Consultants medical case manager will work cooperatively with you and your doctor to monitor and maintain quality appropriate treatment to ensure the most efficient and safe return to work. We will maintain communication with you throughout the duration of the claim.

Will I be paid for the time I miss from work due to my injury?
Ohio University will comply with BWC guidelines. If you miss work for more than seven (7) calendar days because of an allowed work-related injury, your time off work will be paid based upon a percentage of your average weekly earnings. In order to receive payments, all of your time off must be supported by your treating physician.

When do I receive my wage payments?
If your treating physician has taken you off of work, has submitted the appropriate forms and your claim is allowed, benefits will be paid within twenty one (21) days from the date the paperwork is received by CareWorks Consultants.

Do I need a doctor’s release to return to work?
If you have missed work as a result of your injury, your doctor must provide a medical release or fit for duty report in order to return to work. This injury packet contains a standard release form (Medco-14) that is commonly used to identify your work capabilities. Have your doctor complete this form and fax to Ohio University’s Human Resources Department at (740) 597-1993.
**OHIO UNIVERSITY EMPLOYEE INCIDENT REPORT**

**FOR UNIVERSITY EMPLOYEE INCIDENTS:** Supervisor (and employee) must complete form immediately after a work-related injury, illness or incident. *Employee must report any injury to their supervisor/acting supervisor before the end of their shift.* Attach additional sheets if necessary. Supervisors must investigate the incident thoroughly and submit the form within **one working day** to: Human Resources & Training Center Room #118 at 169 W. Union St., by fax at (740) 597-1993, or by phone at (740) 597-1994.

1. **Employee (please check one)** □ Classified □ Administrative □ Bargaining □ Faculty □ Student Employee □ Other (If “other” please describe) ____________________________
2. **Name____________________________**  
3. **Employee #_________**  
4. **Date of Birth_________**  
5. **Gender____**  
6. **Mailing Address_______________________________**  
7. **City_____________**  
8. **State _____**  
9. **Zip_______**  
10. **Home Phone_______________**  
11. **Campus Phone____________**  
12. **Dept _____________________________**  
13. **Bldg/Area/Shop___________________**  
14. **Date Hired__________**  
15. **Job Title______________________**  
16. **Date incident occurred__________**  
17. **Time of Incident_____:_____ AM□ PM□**  
18. **Time Employee Began Work _____:_____AM/PM**
19. **Full name and phone # of any witnesses________________________________________________________**
20. **What was the individual doing and where just before the incident? Describe the activity, any tools, equipment, or material the individual was using/carrying. Be specific. Examples: "climbing a ladder while carrying roofing materials", "leaving Memorial Auditorium through north doors.” Please state the location on campus at time of the incident.________________________________________________________________________________________  
________________________________________________________________________________________  
________________________________________________________________________________________

21. **What happened? How did the injury occur? Examples: "When ladder slipped on wet floor, worker fell 20 feet". Please list any unsafe conditions/acts or violation of safety rules or practices. What went wrong?________________________________________________________________________________________  
________________________________________________________________________________________  
________________________________________________________________________________________

22. **What was the injury or illness? Tell us the part of the body that was affected and how. Be more specific than "hurt" or "pain", or "sore". Examples: "strained lower back", "sprained left ankle".________________________________________________________________________________________  
________________________________________________________________________________________  
________________________________________________________________________________________

23. **What object or substance directly injured the individual? Examples: "concrete floor", “bricks on sidewalk”. If this question does not apply to the incident, leave blank.**

24. **Name of Health Care Provider for this incident __________________________** Dr. _____________ Date: _____________
25. **Was employee performing regular job duties? __Yes __No**  
26. **Was employee trained in the specific job/activity involved in this incident? __Yes (Date Trained: _____________ ) __ No (If No, explain)**

27. **What has been/will be done to prevent this type of incident (corrections, actions, repairs, training, etc.)**

________________________________________________________________________________________  
________________________________________________________________________________________  
________________________________________________________________________________________

28. **Any pre-existing injury/condition of which you’re aware that could have contributed to this ____No ______Yes**
29. **Date injury reported to supervisor by employee _____________**  
30. **Date Investigated _____________** (If date investigated is different from date reported, why? _____________)
31. **Death? ____No ______Yes**  
32. **If yes, date: __________________**
33. **Supervisor’s Name (please print) __________________________**  
34. **Supervisor's Email Address ____________________________________________________________________**  
35. **Signature of injured/ill person __________________________**  
36. **Date Report Completed _____________**

**Notice:** Supervisor: please give a copy of this form to the employee upon completion.

REV 5.16.16
### Bureau of Workers’ Compensation

**First Report of an Injury, Occupational Disease or Death**

**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)

<table>
<thead>
<tr>
<th>Last name, first name, middle initial</th>
<th>Social Security number</th>
<th>Marital status</th>
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<tbody>
<tr>
<td></td>
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<td>Single</td>
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<td>Married</td>
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<td>Divorced</td>
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<td>Separated</td>
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<td>Widowed</td>
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<table>
<thead>
<tr>
<th>Date of birth</th>
<th>Number of dependents</th>
<th>Department name</th>
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<tr>
<th>City</th>
<th>State</th>
<th>9-digit ZIP code</th>
<th>Country if different from USA</th>
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<tr>
<th>Wage rate</th>
<th>Hour</th>
<th>Month</th>
<th>Week</th>
<th>What days of the week do you usually work?</th>
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<tbody>
<tr>
<td>$</td>
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<td>Sun</td>
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<table>
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<tr>
<th>Date last worked</th>
<th>Date returned to work</th>
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</table>

<table>
<thead>
<tr>
<th>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?</th>
<th>Occupation or job title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
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**Ohio University**

**Human Resources & Training Center #118 169 West Union Street Athens, Ohio 45701**

**Location, if different from mailing address**

**Was the place of accident or exposure on employer’s premises?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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<table>
<thead>
<tr>
<th>Date of injury/disease</th>
<th>Time of injury</th>
<th>If fatal, give date of death</th>
<th>Time employee began work</th>
<th>Date last worked</th>
<th>Date returned to work</th>
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<tbody>
<tr>
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<td>a.m.</td>
<td>p.m.</td>
<td>a.m.</td>
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<thead>
<tr>
<th>Description of accident (Describe the sequence of events that directly injured the employee, or caused the disease or death.)</th>
<th>Type of injury/disease and part(s) of body affected (For example: sprain of lower left back)</th>
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**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 inflict. I affirm that I elect to receive compensation and 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, 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 in this claim, the employer’s managed care organization and any 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 employees of record (or their 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.

**Injured worker and injury/disease/death info.**

<table>
<thead>
<tr>
<th>Injured worker signature</th>
<th>Date</th>
<th>E-mail address</th>
<th>Telephone number</th>
<th>Work number</th>
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</table>

**Health-care provider name**

<table>
<thead>
<tr>
<th>Telephone number</th>
<th>Fax number</th>
<th>Initial treatment date</th>
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<table>
<thead>
<tr>
<th>Street address</th>
<th>City</th>
<th>State</th>
<th>9-digit ZIP code</th>
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<tr>
<th>Diagnoses(s): Include ICD codes!</th>
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**Will the incident cause the injured worker to miss eight or more days of work?**

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<tr>
<th>Yes</th>
<th>No</th>
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<table>
<thead>
<tr>
<th>Is the injury causally related to the industrial incident?</th>
<th>11-digit BWC provider number</th>
<th>Date</th>
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**Health-care provider signature**

**Employer policy number**

<table>
<thead>
<tr>
<th>Employer policy number</th>
<th>Check if Employer is self-insuring</th>
<th>Check if Injured worker is owner/partner/member of firm</th>
</tr>
</thead>
<tbody>
<tr>
<td>20005755-O</td>
<td>✓</td>
<td></td>
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</table>

**Telephone number**

<table>
<thead>
<tr>
<th>Telephone number</th>
<th>Fax number</th>
<th>E-mail address</th>
<th>Federal ID number</th>
<th>Manual number</th>
</tr>
</thead>
<tbody>
<tr>
<td>(740) 597-1992</td>
<td>(740) 597-1993</td>
<td><a href="mailto:wines@ohio.edu">wines@ohio.edu</a></td>
<td></td>
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</tbody>
</table>

**Was employee treated in an emergency room?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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<table>
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<tr>
<th>Was employee hospitalized overnight as an inpatient?</th>
<th>Date</th>
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**For self-insuring employers only**

<table>
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<tr>
<th>Certification</th>
<th>Rejection</th>
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**Employer signature and title**

**OSHA case number**

This form meets OSHA 301 requirements

BWC-1101 (Rev. 6/12/2014)

FROI-1 (Combines C-1, C-2, C-3, C-6, C-50, OD-1, OD-1-22)
Authorization to Release Medical Information

You can obtain this form online at ohiobwc.com

Injured worker name (first, M.I., last)  Date of injury  Claim number

Address  City  State  Nine-digit ZIP code

Employer name  Employer MCO or QHP

I, the above-named injured worker, understand I am allowing the Opportunities for Ohioans with Disabilities and the providers (persons or facilities) named here (_____________________________________________________________________________________) that attend or examine me to release the following medical, psychological and/or psychiatric information (excluding psychotherapy notes) that are related causally or historically to physical or mental injuries relevant to my workers’ compensation claim:

• Pathology slides and immunohistochemical staining results, if applicable;
• Hospital admission history and physical; emergency room reports; hospital discharge summaries; physician office notes; physical therapist, occupational therapist or athletic trainer assessments and progress notes; consultation reports; lab results; medical reports; surgical reports; diagnostic reports; procedure reports; nursing home and skilled nursing facilities documentation; home nursing progress notes; or other listed below.

_________________________________________________________

I understand I am authorizing the release of this information to the following: the Ohio Bureau of Workers’ Compensation (BWC), the Industrial Commission of Ohio, the above-named employer, the employer’s managed care organization or qualified health plan and any authorized representatives.

I understand this information is being released to the above-referenced persons and/or entities for use in administering my workers’ compensation claim.

This authorization to release medical, psychological and/or psychiatric information shall remain in effect for as long as my workers’ compensation claim remains open under Ohio law. I understand I have the right to revoke this authorization at any time. However, I must submit my revocation in writing and file it with BWC or my self-insured employer. My decision to revoke this authorization will be effective, except in the case that any provider referenced above already has relied on my authorization and released information.

I understand the provider(s) referenced above may not make my completing and signing this authorization a condition of my treatment.

I understand the parties I am authorizing the release of information to are exempted from the federal privacy requirements of the Health Insurance Portability and Accountability Act of 1996 as they administer workers’ compensation programs. Information disclosed pursuant to this authorization may be redisclosed by them and may no longer be protected by the federal privacy requirements. I understand such redisclosures may include but are not limited to the following:

• A copy of the medical information the employer receives may be forwarded to BWC by the employer;
• A copy of the medical information will be available to me or my physician of record upon request to BWC or to the employer.

Injured worker (or guardian or personal representative) signature  Date

If signed by the injured worker’s guardian or personal representative, provide a description of the guardian or personal representative’s authority to sign on behalf of the injured worker. ________________________________________________________________
Injured worker name

Date of injury

Date of last appointment/examination

Date of this appointment/examination

Date of next appointment/examination

Claim number

MEDCO-14 submission (Select one of the options below.)

1  □ I have never completed a MEDCO-14. Proceed to section 2.
   □ I have previously completed a MEDCO-14, and all of the information remains the same. **Proceed to and complete section 8.**
   □ I have previously completed a MEDCO-14, and I am providing updates to each section checked.

Employment/Occupation Complete this section and proceed to section 3

(Updates Yes □ No □)

2 Have you reviewed the description of the injured worker’s job held on the date of injury (former position of employment)? Yes □ No □
   If yes - please indicate who (select all sources) provided the job description □ Injured worker □ Employer □ MCO □ BWC

Work status/Injured worker’s capabilities

(Updates Yes □ No □)

3A Does the injured worker have any work restrictions related to allowed conditions in the claim? Yes □ No □
   If yes, proceed to section 3B.
   If no restrictions, please indicate release to work date _____/_____/_____. **Proceed to and complete sections 6 and 8.**

3B If there are work restrictions, can the injured worker return to his/her job held on the date of injury (former position of employment)? Yes □ No □
   If yes, please indicate release to work date: _____/_____/_____. **Proceed to sections 3C, 5, 6, and 8.**
   If no, please indicate when the injured worker initially could not do the job held on the date of injury. 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: _____/_____/_____.
   **Proceed to section 3C.**

Please indicate which of the activities listed below the injured worker can perform (even if the response to 3B is “no”.)
The injured worker can perform simple grasping with: □ Left hand □ Right hand □ Both
The injured worker can perform repetitive wrist motion with: □ Left hand □ Right hand □ Both
The injured worker’s dominant hand is: □ Left □ Right
The injured worker can perform repetitive actions to operate foot controls or motor vehicles with: □ Left foot □ Right foot □ Both If the injured worker is taking prescribed medications for the allowed conditions in this claim, is the injured worker able to safely:
   *Operate heavy machinery: □ Yes □ No
   *Drive: □ Yes □ No
   *Perform other critical job tasks as defined by any source listed above in section 2: □ Yes □ No

Please indicate the following: N = Never, O = Occasionally, F = Frequently, C = Continuously

<table>
<thead>
<tr>
<th>Activity</th>
<th>N</th>
<th>O</th>
<th>F</th>
<th>C</th>
<th>Lifting/carrying</th>
<th>N</th>
<th>O</th>
<th>F</th>
<th>C</th>
<th>Pushing/pulling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bend</td>
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<td></td>
<td></td>
<td>0 - 10 lbs.</td>
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<td></td>
<td></td>
<td></td>
<td>0 to 25 lbs.</td>
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<tr>
<td>Reach above shoulder</td>
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<td></td>
<td></td>
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<td>11 - 20 lbs.</td>
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<td></td>
<td></td>
<td>26 to 40 lbs.</td>
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<tr>
<td>Squat/kneel</td>
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<td>21 - 40 lbs.</td>
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<td>41 to 60 lbs.</td>
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<tr>
<td>Type/keyboard</td>
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<td></td>
<td>41 - 60 lbs.</td>
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<td></td>
<td>61 to 100 lbs.</td>
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<tr>
<td>Work with cold substances</td>
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<td></td>
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<td></td>
<td>61 - 100 lbs.</td>
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<td></td>
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<td>100 + lbs.</td>
</tr>
<tr>
<td>Work with hot substances</td>
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</tbody>
</table>

3C In an eight-hour workday, how many total hours is the injured worker able to:
   Sit: _____ hours □ Continuously □ With break
   Walk: _____ hours □ Continuously □ With break
   Stand: _____ hours □ Continuously □ With break
In the space below please provide any additional information addressing the injured worker’s capabilities and/or job accommodations which may not be addressed above.

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
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.

<table>
<thead>
<tr>
<th>Narrative description of the work-related allowed condition</th>
<th>Site/location if applicable</th>
<th>ICD code</th>
<th>Is the condition preventing full duty release to the job injured worker held on the date of injury?</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Yes □ No □</td>
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<td>Yes □ No □</td>
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<td></td>
<td>Yes □ No □</td>
</tr>
</tbody>
</table>

List all other relevant conditions that impact treatment of the conditions listed above (e.g., co-morbidities or not yet allowed conditions).

The injured worker is progressing: □ As expected □ Better than expected □ 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.

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 □ No □

If yes, give MMI date: _____/_____/_____. If no, please provide the proposed treatment plan, including estimated duration of each treatment (attach additional sheet if necessary).

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.

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 □ No □ If no, please explain why and provide your recommendations to help the injured worker return to employment.

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.

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Modern Medical

Instant Access Cards

Ohio University

Acct #: _____