

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 pen or electronically (do not use pencil).

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 notify your supervisor immediately (within 24 hours) after any accident or onset of illness.

- Follow your specific agency's accident procedures
- Provide the exact date and time the accident occurred
- Provide the exact date and time the incident was reported
- List to whom (name, title and phone #) you reported the incident
- Did you seek on-site medical treatment? Check yes or no. If yes, provide details of treatment rendered in "nature of Injury/Illness" section.
- Be sure to indicate name of outside medical provider

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

- **Salary Continuation (SC)** – SC is equal to the employee's total rate of pay not to exceed 480 hours per workers' compensation claim and paid by the employer.
- **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.ohiobwc.com for specific details.
- **Occupational Injury Leave (OIL)** – An employee who incurs a work-related injury or illness inflicted by a ward of the State may be entitled to OIL. OIL is equal to the employee's total rate of pay not to exceed 960 hours per workers' compensation claim and paid by the employer. Refer to your specific bargaining unit contract for details.

Employee Accident Description

You must explain in detail how you were injured, including

- What caused injury/illness
- Where did the accident occur
- How did the accident occur
- What were you doing at the time of the accident
- Location should include name of building/area and the location within the building/area
- List any witnesses to the incident

Nature of Injury/Illness

Indicate the body part affected and the illness or injury that resulted from the incident. Include details of any medical attention sought or that you plan to seek.

Injured Worker Signature/Date

Please read and complete this form in its entirety. Date and sign this report and return to your employing agency designee/personnel officer.

Injury / Illness Report

Employee Statement (to be completed by employee)

Please read the instructions before completing

Check all that apply:

- Full time Employee
 Part-time Employee
 Interim Employee
 Exempt
 Seasonal / temp
 Other: _____

- OCSEA
 Unit _____
 FOP Unit 2
 1199
 ORC 124.381
 ORC 124.15
 OSTA
 Other: _____

PERSONAL INFORMATION

Employee's name:

Address (Street / City / State / Zip):

Social Security #:

Phone # (Home / Work):

Date of Birth:

Age:

Sex:

Your employer's name:

Job Title:

Employer's BWC Policy #:

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

Scheduled Work Days (Circle): 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 the benefit type requested:

- Salary Continuation
 Temporary Total Compensation
 Occupational Injury Leave; inflicted by a ward of the State (inmate, patient, resident, client, youth or student)

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: (Circle) Yes No If yes, employer name:

EMPLOYEE ACCIDENT 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.)

NATURE OF ILLNESS/INJURY (PLEASE BE VERY SPECIFIC)

Indicate body part(s) affected:

Describe the illness or injury resulting from the incident:

On-site medical treatment sought/rendered? (circle): Yes No

If yes, from?

Clinician observation / assessment:

Clinician initials: _____

Outside medical treatment sought/rendered? (circle): Yes No (If yes, provide the **name and phone number** of medical provider below)

Physician's name & phone #:

Benefit application/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 the Ohio 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, and the Ohio Rehabilitation Services Commission (where relevant) to release medical, psychological, psychiatric, vocational or social 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. I understand that social security numbers are used to match individuals with other employment records that may be required in the processing of this claim and are used for informational purposes only. A photocopy of this authorization shall be as valid as the original.

Employee Signature

Date

Injury / Illness Report

Employer Statement *(to be completed by WC designee)*

Date received by personnel:

EMPLOYER INFORMATION

BWC Claim #
and/or injury date:

Employee's Name:

Agency (Specify operating location
or Central Office):

BWC Policy #:

Address (Street / City / State / Zip):

Work County:

Hire date:

Employment type (Circle): PT FT Interim Temp

Bargaining Unit Status (Circle) : OCSEA Unit _____ FOP 1199 Exempt Other:

Did employee seek nursing/first aid care? (circle) Yes No

If yes, from?

Employee has applied for payment under: (circle) Salary Continuation OIL WC-TTD Disability Other: _____

Was employee off work seven (7) consecutive days? (circle) Yes No

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

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

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

Has the employee returned to work? (circle) Yes No

DATE _____

If YES, give ACTUAL date:

If NO, give estimated RTW date:

Was a Transitional Work Assignment offered to this employee? (circle) Yes No

Is a Job Analysis and / or Position Description attached? (circle) Yes No

Did this injury result in a fatality? (circle) Yes No

If yes, give date of death:

Date faxed/called in 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:

Coordinator's initials:

Date employee became disabled:

Total hours being requested:

Comments:

Treating with an approved physician (circle) 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 (to be 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 accident (What occurred, what was the injury type, what object directly harmed the employee?):

What was the employee doing immediately before the accident?:

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: