

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 POLICY.**

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

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 #:

Work County:

EMPLOYER INFORMATION

Employee's Name:

Agency (Specify operating location
or Central Office):

Address (Street / City / State / Zip):

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:

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: