

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.

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

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.

- **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
- ***** 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. SC is effective the date of the injury and does not require a waiting period.
- ***** 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, as OIL applies to certain agencies.

WILMAPC PROVIDER

***** IN ORDER TO RECEIVE SALARY CONTINUATION OR OCCUPATIONAL INJURY LEAVE, YOU MUST SEEK MEDICAL TREATMENT FROM A PHYSICIAN ON THE WILMAPC APPROVED PHYSICIAN LIST IF YOU ARE INJURED ON THE JOB AND QUALIFY.**

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

<http://www.das.ohio.gov/Divisions/CollectiveBargaining/Wilmapc/tabid/479/Default.aspx>

Employee Accident Description

You must explain in DETAIL how you were injured, including

- What caused injury/illness, where the accident occurred, how the accident occurred, explain what you were doing at the time of the accident, include the ACTUAL SPECIFIC location where the incident occurred and 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.

- 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

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."



Injury / Illness Report

Employee Statement (completed by employee)

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

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*; inflicted by a ward of the State (inmate, patient, resident, client, youth or student)
- *Must seek medical treatment from 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 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? ___ Yes ___ No

If yes, from? _____

Clinician observation / assessment:

 Clinician initials: _____

Outside medical treatment sought/rendered? ___ 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

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 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: