

# Accident or Illness Report

## Employee Statement

Please read instructions on back of form before completing

<b>FOR OFFICE USE ONLY</b>
Date Received:

### PERSONAL INFORMATION

Employee's Name				Social Security Number	
Address		Street	City	State	Zip
Telephone	Home	Work	Agency	Employee ID Number	
Date of Birth	Age		Sex	Job Title	

### INCIDENT REPORT INFORMATION

Date/Time of Injury			Date/Time Reported		
Reported to:	Name	Title	Phone Number		

### EMPLOYEE ACCIDENT DESCRIPTION

Give cause, location of accident, how it occurred and what you were doing

### NATURE OF ILLNESS/INJURY

Indicate body part affected and the illness or injury resulting from the incident

On-site medical treatment sought/rendered? <input type="checkbox"/> Yes <input type="checkbox"/> No	From:
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Observations/Assessment:

Outside medical treatment sought/rendered' <input type="checkbox"/> Yes <input type="checkbox"/> No
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If yes, please provide name and phone number of provider (may be doctor, hospital, clinic, etc)

Pursuant to O.R.C. Sec. 2921.13, "No person shall knowingly make a false statement...with purpose to secure the payment of workers' compensation..." I am applying for recognition of my claim under the Ohio Workers' Compensation Act for work-related injuries that I did not purposefully inflict. I request payment for compensation and/or medical expenses as allowable. Direct payment(s) to the providers of any medical services are authorized. I understand that I am allowing any provider that attends to, treats or examines me to release all medical, psychological, and/or psychiatric information that is related to my workers' compensation claim to the Ohio Bureau of Workers' Compensation, the Ohio Industrial Commission, DAS, employing agency and their authorized representative(s). 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.

Signature	Date
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**DISTRIBUTION:** DAS (Workers' Comp section) / Employee / Physician

# Accident or Illness Report

## Employer Statement

Please read instructions on back of form before completing

<b>FOR OFFICE USE ONLY</b>
Date Received:

<b>EMPLOYER INFORMATION</b>		
Employee's Name	Social Security Number	
Agency's Name	Employee ID Number	
Address	Street	City State Zip
Risk/Manual Number	OSHA Case Number	
Did employee seek nursing/first aid care? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, from whom?	
Has employee applied for payment under disability leave, occupational injury leave or other programs? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, list program:		
Was this employee off work seven (7) consecutive days? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, attach Calendar of Wage (ADM4741) and gross wages for the year prior to the date of injury.		
Has the employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, give date:	
Can your agency provide Transitional Work Assignments? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Was a transitional work assignment offered to this employee? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Did this illness/injury result in a fatality? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, give date of death	
Date faxed/called in to the MCO:	By whom:	
Do you feel that this claim is valid? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, please comment below:	
Agency Representative Signature and Title	Date	Phone Number

### \* \* \* \* FOR DAS USE ONLY \* \* \* \*

<input type="checkbox"/> <b>CERTIFICATION</b> The employer certifies that the facts in this application are correct and valid	<input type="checkbox"/> <b>REJECTION</b> The employer rejects the validity of this claim for the following reasons:	
Employer Signature and Title	Date	Phone Number

**DISTRIBUTION: DAS (Workers' Comp section) / Employee / Physician**

# Instructions for Accident or 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 use a typewriter (do not use pencil).

## **Employee Statement**

The injured employee is responsible for completing the following sections:

1. **Personal Information - Please fully complete all requested information.**
2. **Incident Report Information**

You must notify your supervisor immediately after any accident or the onset of illness.

- Follow your 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 number) 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

3. **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
- list any witnesses to the incident

4. **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.

5. **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.

## **Employer Information**

To be completed by agency designee/ personnel officer.

- Complete Employer name, address, risk/manual number
- Please complete all requested information
- Please indicate if you feel that this is a valid claim. If not, attach a detailed statement.
- Sign the form.
- Once complete, fax pages 1 and 2 of the ADM 4303 to CompManagement at (614) 764-1749.

## **FOR AUTHORIZED USE ONLY**

DAS' Third Party Administrator for Workers' Compensation, CompManagement, certifies or rejects applications for Workers' Compensation benefits on behalf of the majority of state agencies.