RESET

LICKING HEIGHTS LOCAL SCHOOL DISTRICT

EMPLOYEE ACCIDENT REPORT

_____
SCHOOL / BUILDING

Name of Injured employee: _____

Date of accident: _____ Time of accident: _____

Location of accident: On the Job ☐ Off the Job ☐

Describe how the accident occured: _____

_____

Nature of injuries: _____

Is medical assistance required: Yes ☐ No ☐

Witness to Injury: Yes ☐ No ☐

Witness name (if yes) _____

Person completing this report: _____

Injured employee signature: _____

Principal / Supervisor Signature: _____

Please provide a copy of report to:

Human Resource's
Superintendent
Principal/Supervisor
Treasurer

NOTICE: Please notify the Principal and/or Supervisor immediately of injury

Licking Heights Schools

INJURY ON THE JOB CLAIM PROCEDURES

EMPLOYER AND BWC POLICY #:		YOUR WC COORDINATOR:	
Name:	Licking Heights Schools	**Name:**	Nick Roberts
Address:	6539 Summit Rd SW	**Dept:**	Treasurer
City, State, Zip:	Pataskala, OH 43073	**Phone:**	740-927-6926
BWC Policy Number:	**34554651-0**	**Email:**	**njroberts@laca.org**

IF YOU EXPERIENCE AN ON THE JOB INJURY:

1. **Notify your Supervisor IMMEDIATELY.**
2. **In an Emergency, seek care at the nearest medical facility.**
3. **For non-Emergency situations where medical treatment is necessary, your supervisor will direct you to**

   Ohio Health Urgent Care
   2014 Baltimore – Reynoldsburg Rd
   Reynoldsburg, OH
   614-522-6900

4. **Give your MCO Identification Card and MEDCO-14 Form (provided) to one of the medical providers listed above. The medical provider will have you fill out the first report of injury (FROI) and will fax it to CompManagement Health Systems at (800) 334-4229.**
5. **CompManagement Health Systems will report your injury to the Ohio BWC and assign a case manager to help with your recovery.**
6. **You must provide information regarding your medical condition, disability, anticipated return-to-work, and work restrictions to your workers' compensation coordinator immediately.**

Key Contact Information

FAX Medical Information Toll-free to CHS at (800) 334-4229 **Mail Medical Information** CHS PO Box 1040 Dublin, OH 43017	**Mail Medical Information** CHS PO Box 1040 Dublin, OH 43017 **Billing Questions Call** Customer Service toll-free (888) 247-7799	**Prescription Info** Contact ACS State Healthcare toll-free at (800)OHIOBWC, Option 5 **Ohio BWC** (800)OHIOBWC

key contact information

Medical management

FAX medical information:
800.334.4229

MAIL medical information:
CHS
PO Box 1040
Dublin, OH 43017

Prior authorization:
Fax C-9 form to 800.334.4229

Medical bill payment

MAIL medical bills:
CHS
PO Box 1040
Dublin, OH 43017

Billing questions:
Call CHS Customer Service
toll-free at 888.247.7799

Other

Prescriptions:
For questions regarding prescriptions, contact Catamaran at 877.615.6330

Provider search:
Visit www.chsmco.com for provider searches

PO Box 1040, Dublin, OH 43017 | 7731 E. Kemper Road, Cincinnati, OH 45249
5700 Lombardo Center Drive, Ste 150, Seven Hills, OH 44131 | 3130 Executive Pkwy, Ste 2F, Toledo, OH 43606

888.247.7799 | www.**chsmco**.com

compmanagement health systems

CompManagement Health Systems

Workers' Compensation Identification Card

1 (888) 247-7799 Customer Service
1 (888) 247-4800 Injury Report Number

State Insured Employer
LICKING HEIGHTS SCHOOLS
34551651-0

compmanagement health systems

Prescription questions: contact the Pharmacy Benefits Manager at 1 (800) 644-6292 press 0, select option 3, then select option 2.

An Access to Care Guide

IN THE CASE OF ILLNESS OR INJURY

Regardless of your concern, OhioHealth has you covered with the following healthcare options:

DON'T HAVE A PCP?

Select Find a Doctor at **ohiohealth.com** or call **(614) 4-HEALTH (443.2584)** to find a primary care physician. It's the first step to your best health.

URGENT CARE

For allergies, sinus infections, cold and cough, sore throat, earaches, fever, flu-like symptoms, rashes, and minor burns and other non-life-threatening needs.

1 OHIOHEALTH URGENT CARE — DUBLIN
6905 Hospital Drive, Suite 130
(614) 923.0300
9 a.m. – 9 p.m., 7 days a week

2 OHIOHEALTH URGENT CARE — GAHANNA/NEW ALBANY
5610 Hamilton Road
(614) 775.9870
8 a.m. – 8 p.m., 7 days a week

3 OHIOHEALTH URGENT CARE — GRANDVIEW
895 West 3rd Avenue
(614) 437.0278
9 a.m. – 7 p.m., 7 days a week

4 OHIOHEALTH URGENT CARE — GROVE CITY
2030 Stringtown Road
(614) 883.0160
9 a.m. – Midnight, 7 days a week

5 OHIOHEALTH URGENT CARE — HILLIARD
4343 All Seasons Drive, Suite 160
(614) 541.2676
9 a.m. – 7 p.m., 7 days a week

6 OHIOHEALTH URGENT CARE — LEWIS CENTER
24 Hidden Ravines Drive
(740) 549.2700
9 a.m. – 7 p.m., 7 days a week

7 OHIOHEALTH URGENT CARE — POLARIS
1120 Polaris Parkway
(614) 847.1120
9 a.m. – 9 p.m., 7 days a week

8 OHIOHEALTH URGENT CARE — REYNOLDSBURG
2014 Baltimore-Reynoldsburg Road
(614) 522.6900
9 a.m. – 7 p.m., 7 days a week

EMERGENCY SERVICES

For life-threatening conditions such as heart attack and stroke, chest pain, difficulty breathing, severe bleeding, head injury, loss of consciousness, or other major trauma.

DH OHIOHEALTH DOCTORS HOSPITAL
Emergency Department
5100 West Broad Street

DM OHIOHEALTH DUBLIN METHODIST HOSPITAL
Emergency Department
7500 Hospital Drive

GM OHIOHEALTH GRADY MEMORIAL HOSPITAL
Emergency Department
561 West Central Avenue

GR OHIOHEALTH GRANT MEDICAL CENTER
Emergency Department
111 South Grant Avenue

RM OHIOHEALTH RIVERSIDE METHODIST HOSPITAL
Emergency Department
3535 Olentangy River Road

WM OHIOHEALTH WESTERVILLE MEDICAL CAMPUS
Emergency Care Center
260 Polaris Parkway

WORKHEALTH CENTERS

Specializes in the care of work-related injuries and illnesses. To schedule an appointment call **(614) 566-WORK (9675)**.

9 OHIOHEALTH WORKHEALTH – DELAWARE
801 OhioHealth Boulevard
8 a.m. – 4:30 p.m., Monday–Friday

10 OHIOHEALTH WORKHEALTH – GRANDVIEW
895 West 3rd Avenue
Columbus, Ohio 43212
7:30 a.m. – 4:30 p.m., Monday–Friday

11 OHIOHEALTH WORKHEALTH – GROVE CITY
4079 Gantz Road, Suite C
7 a.m. – 4 p.m., Monday–Friday

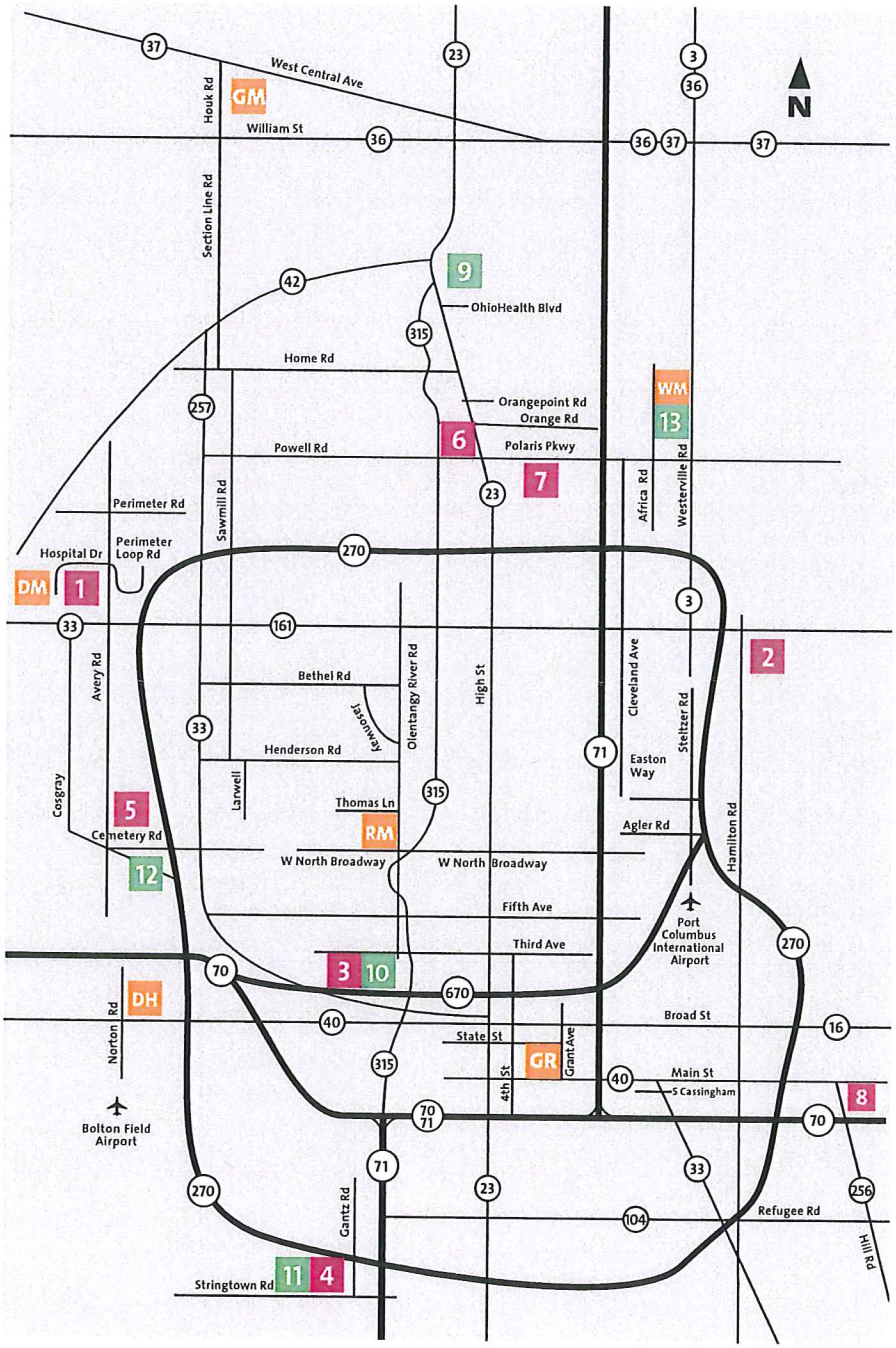
12 OHIOHEALTH WORKHEALTH – HILLIARD
4523 Cemetery Road
7 a.m. – 4 p.m., Monday–Friday

13 OHIOHEALTH WORKHEALTH – WESTERVILLE
300 Polaris Parkway
7:30 a.m. – 4:30 p.m., Monday–Friday

OhioHealth
BELIEVE IN *WE*™

Total Health & Wellness

Visit **ohiohealth.com** to find primary care and specialty physician office locations or to learn more about OhioHealth's entire spectrum of healthcare offerings, from prevention screenings to rehabilitation services.



- EMERGENCY SERVICES
- URGENT CARE
- WORKHEALTH CENTERS

A FAITH-BASED, NOT-FOR-PROFIT HEALTHCARE SYSTEM

RIVERSIDE METHODIST HOSPITAL + GRANT MEDICAL CENTER + DOCTORS HOSPITAL + GRADY MEMORIAL HOSPITAL
DUBLIN METHODIST HOSPITAL + DOCTORS HOSPITAL–NELSONVILLE + HARDIN MEMORIAL HOSPITAL
MARION GENERAL HOSPITAL + REHABILITATION HOSPITAL + O'BLENESS HOSPITAL + MEDCENTRAL MANSFIELD HOSPITAL
MEDCENTRAL SHELBY HOSPITAL + WESTERVILLE MEDICAL CAMPUS + HEALTH AND SURGERY CENTERS + PRIMARY AND SPECIALTY CARE
URGENT CARE + WELLNESS + HOSPICE + HOME CARE + 28,000 PHYSICIANS, ASSOCIATES & VOLUNTEERS

OhioHealth
BELIEVE IN *WE*™

Ohio | Bureau of Workers' Compensation

First Report of an Injury, Occupational Disease or Death

By signing this form, I:
- **Elect to only receive compensation and/or benefits that are provided for in this claim under Ohio workers' compensation laws;**
- **Waive and release my right to receive compensation and benefits under the workers' compensation laws of another state for the injury or occupational disease, or death resulting from an injury or occupational disease, for which I am filing this claim;**
- **Agree that I have not and will not file a claim in another state for the injury or occupational disease or death resulting from an injury or occupational disease for which I am filing this claim;**
- **Confirm that I have not received compensation and/or benefits under the workers' compensation laws of another state for this claim, and that I will notify BWC immediately upon receiving any compensation or benefits from any source for this claim.**

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)

Injured worker and injury/disease/death info.

Last name, first name, middle initial			Social Security number	Marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	Date of birth
Home mailing address			Sex ☐ Male ☐ Female		Number of dependents
City	State	9-digit ZIP code	Country if different from USA		Department name
Wage rate $ _____ Per: ☐ Hour ☐ Month ☐ Week ☐ Year ☐ Other _____			What days of the week do you usually work? ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat		Regular work hours From _____ To _____
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? ☐ Yes ☐ No If yes, please explain.					Occupation or job title

Employer name

Mailing address (number and street, city or town, state, ZIP code and county)

Location, if different from mailing address

Was the place of accident or exposure on employer's premises? ☐ Yes ☐ No
(If no, give accident location, street address, city, state and ZIP code)

Date of injury/disease	Time of injury _____ ☐ a.m. ☐ p.m.	If fatal, give date of death	Time employee began work _____ ☐ a.m. ☐ p.m.	Date last worked	Date returned to work
Date hired	State where hired		Date employer notified	State where supervised	

Description of accident (Describe the sequence of events that directly injured the employee, or caused the disease or death.)	Type of injury/disease and part(s) of body affected (For example: sprain of lower left back)

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 employers 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 signature	Date	E-mail address	Telephone number	Work number ( )

Treatment info.

Health-care provider name	Telephone number ( )	Fax number ( )	Initial treatment date
Street address	City	State	9-digit ZIP code

Diagnosis(es): Include ICD code(s)

Will the incident cause the injured worker to miss eight or more days of work? ☐ Yes ☐ No	Is the injury causally related to the industrial incident? ☐ Yes ☐ No	
E code	11-digit BWC provider number	Date
Health-care provider signature		

Employer info.

Employer policy number	Check if ☐ Employer is self-insuring ☐ Injured worker is owner/partner/member of firm			
Telephone number ( )	Fax number ( )	E-mail address	Federal ID number	Manual number

Was employee treated in an emergency room? ☐ Yes ☐ No	Was employee hospitalized overnight as an inpatient? ☐ Yes ☐ No

If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code

☐ **Certification** - The employer certifies that the facts in this application are correct and valid.

☐ **Rejection** - The employer rejects the validity of this claim for the reason(s) listed below:

For self-insuring employers only
☐ **Clarification** - The employer clarifies and allows the claim for the condition(s) below:
☐ **Medical only** ☐ **Lost time**

Employer signature and title	Date	OSHA case number

Ohio | Bureau of Workers' Compensation

Physician's Report of Work Ability

Injured worker name	Claim number	Date of injury
Employer name and injured worker's position of employment at time of injury	Date of last exam or treatment	Next appointment date

Injured worker progress

1 The injured worker is progressing: ☐ As expected ☐ Better than expected ☐ Slower than expected

If a MEDCO-14 was previously completed for this injured worker, are there any changes to the information provided in Section 2 through 7 to report at this time? ☐ Yes ☐ No *If yes, proceed to section 2. If no, proceed to section 8.*

Work status

Did you review a description of the injured worker's job duties as they existed on the date of injury (former position of employment)? Check all applicable boxes.

☐ Yes, I was provided a job description (verbal or written) by the ☐ Injured worker ☐ Employer ☐ MCO

☐ No, I have not been provided a job description.

Select one of the three options below.

2 ☐ Injured worker is temporarily not released to any work, including the former position of employment from (date): ____/____/____ to ____/____/____. *Please complete required sections 4, 5, 6, 7 and 8.*

☐ Injured worker is not released to the former position of employment but may return to available and appropriate work with restrictions, from (date): ____/____/____ to ____/____/____. *Please complete required sections 3, 4, 5, 6, 7 and 8.*

The restrictions are: ☐ Permanent ☐ Temporary If temporary until what date? ____/____/____

☐ Injured worker is released to the former position of employment without restrictions as of (date): ____/____/____.

Is this date the day the injured worker actually returned to work? ☐ Yes ☐ No ☐ I don't know: *Proceed to section 8 and complete it.*

Injured worker's capabilities: Employer will use information in this section to evaluate available and appropriate work opportunities

How many total hours is this injured worker potentially able to work? _____ Hours in a day _____ Hours in a week

Upper extremities

The injured worker is able to perform simple grasping with: ☐ Left hand ☐ Right hand ☐ Both

The injured worker is able to perform repetitive wrist motion with: ☐ Left hand ☐ Right hand ☐ Both

The injured worker's dominant hand is: ☐ Left ☐ Right

Lower extremities

The injured worker is able to perform repetitive actions to operate foot controls or motor vehicles with: ☐ Left foot ☐ Right foot ☐ Both

Medications

The injured worker is able to safely perform work duties which, if applicable, may include operating heavy machinery or driving while taking prescribed medications: ☐ Yes ☐ No

If no, what are the potential side effects: ☐ Dizziness ☐ Drowsiness ☐ Impaired ability ☐ Other, please explain

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

Lifting/carrying	N	O	F	C	Pushing/pulling	N	O	F	C	Activity	N	O	F	C	Activity	N	O	F	C
0 – 10 lbs.					13 to 25 lbs.					Bend					Reach above shoulder				
11 – 20 lbs.					26 to 40 lbs.					Squat					Type/keyboard				
21 – 40 lbs.					41 to 60 lbs.					Kneel					**Driving**				
41 – 60 lbs.					61 to 100 lbs.					Twist/turn					Automatic				
61 – 100 lbs.					100 + lbs.					Climb					Standard shift				

In an eight-hour workday, how many total hours is the injured worker potentially able to work?

Sit: ___ hours ☐ Continuously ☐ With break | **Walk:** ___ hours ☐ Continuously ☐ With break | **Stand:** ___ hours ☐ Continuously ☐ With break

Degree of functional impairment based on allowed psychological conditions only, if applicable.

	None	Mild	Moderate	Marked	Extreme
Activities of daily living: Self-care, personal hygiene, communication, ambulation, travel, sexual function, sleep, social and recreational activities and occupational functioning	☐	☐	☐	☐	☐
Social functioning: Capacity to interact and communicate effectively and get along with others	☐	☐	☐	☐	☐
Concentration, persistence and pace: Ability to sustain focused attention long enough to complete tasks commonly found in the workplace	☐	☐	☐	☐	☐
Adaptation: Ability to appropriately react to stressful circumstances, including the workplace; includes attendance, making decisions, scheduling or completing tasks and interacting with supervisors and co-workers	☐	☐	☐	☐	☐

Injured worker name	Claim number	Date of injury

Disability period information (all fields required, including site/location if applicable)

4 Complete the chart below and furnish the narrative description of the diagnosis(es), site/location, if applicable, and ICD code for the conditions being treated due to the work-related injury. Please indicate if the condition is causing temporary total disability **(all fields required, including site/location, if applicable).**

Narrative description of the work-related condition	Site/Location If applicable	ICD code	Is the condition causing temporary total disability?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

List all other conditions being treated (attach additional sheet if necessary).

Clinical findings

5 Provide your clinical and objective findings supporting your medical opinion outlined on this form. List any barriers to return to work and any reason for the injured worker's delay in recovery.

Maximum medical improvement (MMI)

6 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. An injured worker may need supportive treatment to maintain this level of function. Note: periodic medical treatment may still be requested and provided.

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).

Vocational rehabilitation

7 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.

Treating physician signature - mandatory

I certify the above information 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, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

8

Treating physician's name (please print legibly)			Physician PEACH number	
Address	City	State	Nine-digit ZIP code	Telephone number – –
Treating physician signature			Date	Fax number – –