Employee Accident/Injury Report

Employee Information:

Name: _____

Home Address: _____

Department: _____ Job Title: _____

Accident/Injury Information:

Date of Accident/Injury: _____ Time of Accident/Injury: _____

Being as detailed as possible, describe the injury and what the employee was doing when the accident/injury occurred. Describe the activity as well as any tools, equipment or materials being used at the time.

Being as detailed as possible, describe the affected part(s) of the body and how those part(s) were affected (example: lower back strain).

Was any first aid provided at the scene? If yes, please describe in detail.

Witnesses to Accident/Injury: _____

Was this part of the normal job duty? _____

Authorization to Release Medical Information

I have completed the BWC form C-101 Authorization to Release Medical Information attached to this Injury Report.
I understand that it is my right to apply for Workers Compensation benefits and that I have two years from the date of this accident/injury to do so.

Employee Signature: _____ Date: _____

Supervisor's Information

Name: _____ Phone: _____

This accident/injury was reported to me on (date) _____ Is further investigation required? (yes/no)

Supervisor's Signature: _____ Date: _____

Ohio | Bureau of Workers' Compensation

Authorization to Release Medical Information

Instructions
- Please print or type.

You can obtain this form online at ***www.bwc.ohio.gov***

- List the provider(s) you are authorizing to release medical records in the space indicated on this form.
- Please sign and date the form, and send it to the customer service office where your claim is located or to your self-insured employer.

Injured worker name (first, M.I., last)		Date of injury		Claim number
Address	City		State	Nine-digit ZIP code
Employer name	Employer MCO or QHP			

I, the above-named injured worker, understand I am allowing the Opportunities for Ohioans with Disabilities and the providers (persons or facilities) named here **(Community Mercy Occupational Health & Medicine, Springfield Regional Hospital, PLEASE LIST OTHERS AS NEEDED)** that attend or examine me to release the following medical, psychological and/or psychiatric information (excluding psychotherapy notes) that are related causally or historically to physical or mental injuries relevant to my workers' compensation claim:

- Pathology slides and immunohistochemically staining results, if applicable;
- Hospital admission history and physical; emergency room reports; hospital discharge summaries; physician office notes; physical therapist, occupational therapist or athletic trainer assessments and progress notes; consultation reports; lab results; medical reports; surgical reports; diagnostic reports; procedure reports; nursing home and skilled nursing facilities documentation; home nursing progress notes; or other listed below.

_____.

I understand I am authorizing the release of this information to the following: the Ohio Bureau of Workers' Compensation (BWC), the Industrial Commission of Ohio, the above-named employer, the employer's managed care organization or qualified health plan and any authorized representatives.

I understand this information is being released to the above-referenced persons and/or entities for use in administering my workers' compensation claim.

This authorization to release medical, psychological and/or psychiatric information shall remain in effect for as long as my workers' compensation claim remains open under Ohio law. I understand I have the right to revoke this authorization at any time. However, I must submit my revocation in writing and file it with BWC or my self-insured employer. My decision to revoke this authorization will be effective, except in the case that any provider referenced above already has relied on my authorization and released information.

I understand the provider(s) referenced above may not make my completing and signing this authorization a condition of my treatment.

I understand the parties I am authorizing the release of information to are exempted from the federal privacy requirements of the Health Insurance Portability and Accountability Act of 1996 as they administer workers' compensation programs. Information disclosed pursuant to this authorization may be redisclosed by them and may no longer be protected by the federal privacy requirements. I understand such redisclosures may include but are not limited to the following:

- A copy of the medical information the employer receives may be forwarded to BWC by the employer;
- A copy of the medical information will be available to me or my physician of record upon request to BWC or to the employer.

Injured worker (or guardian or personal representative) signature	Date

If signed by the injured worker's guardian or personal representative, provide a description of the guardian or personal representative's authority to sign on behalf of the injured worker. _____.