Workers Compensation Injury Checklist

OHIO

WHAT TO DO		
☐	Do they need emergency treatment?	**ER will not be covered if not life threatening**
☐	Can you administer minor first aid?	
	If injured employee is going to go to the doctor, complete the following forms: ☐ State First Report of Injury Form ☐ **Complete drug screen for ALL incidents reported** ☐ Authorization for Treatment Form ☐ Pharmacy Form ☐ Medical Records Release Form ☐ Modified Duty Form	Get all details, WHEN, WHY, WHAT, HOW even if they refuse medical care. They can change their mind later. If they refuse treatment, **they still need a drug screen immediately when they report incident.** Take a picture of injury if appropriate
	If employee does not want to be treated beyond basic first aid, complete the: ☐ First Report of Injury ☐ Drug Screen ☐ Refusal for Treatment Form (make sure the employee signs this form)	**If they ask where to go or do not have a preference, send them to the clinic you normally send injured workers to. MAKE SURE THAT THE** EE fills out Designated Physician Form & **Signs it.**
	Treatment: The employee must be treated by a BWC Certified Physician, except for the Emergency Room, unless it is an **ACTUAL** emergency.	**They Must Have a Drug Screen Immediately After Reporting Incident.**
☐	Send completed forms to sreynolds@wisestaffinggroup.com with a brief explanation in the email	Injuries Must Be Reported Same Day
☐	Will the client allow the employee back for light duty? **Keep in Mind the 7-day waiting period; we must get injured workers back to at least light duty before the 7-day waiting period ends.**	Communicate all known follow up information to sreynolds@wisestaffinggroup.com

For any questions, please call:
Sherry Reynolds-Risk Manager & Employee Benefits
662-685062 ex 1010 (office)
662-523-7890 (cell)

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 ☐ Hour ☐ Month ☐ Week $ _____ Per: ☐ 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

"Merging Talent with Opportunity"

Drug Screen Authorization

Any employee who has a positive result for alcohol or any of the illegal substances listed, will be immediately terminated. In addition, any employee who refuses to submit to the testing procedure will be immediately terminated.

Printed Applicant Name:_____Social Security #:_____

Circle Company Screening For: WISE LABOR SOURCE ONESOURCE RMG

Person Performing Test:_____

Time In: _____ Time Out:_____ Lot #:_____ Expiration Date:_____

Temperature of Sample:_____

Results for: 2-Panel 5-Panel 10-Panel 12-Panel K2 Strip		
Cocaine (COC)	Positive	Negative
Marijuana (THC)	Positive	Negative
Amphetamine (AMP)	Positive	Negative
Opiate (OPI)	Positive	Negative
Methamphetamine (MET)	Positive	Negative
Benzodiazepine (BZO)	Positive	Negative
Phencyclidine (PCP)	Positive	Negative
Barbiturate (BAR)	Positive	Negative
Methadone (MTD)	Positive	Negative
Methylenedioxymethamphetamine (MDMA)	Positive	Negative
Methamphetamines (mAMP)	Positive	Negative
Tricyclic Antidepressants (TCA)	Positive	Negative
K2	Positive	Negative

List any drugs taken in the last 30 days:_____

I hereby authorize and give Wise Staffing Group and entities (Wise Staffing Services, Inc., Labor Source LLC., Onesource Staffing, LLC., Resource Management Group, LLC.) full permission to release the results of this test to the company I am screening for. Such waived and released to claims include but not limited to, invasion of privacy, intentional infliction of mental distress, handicap discrimination, and possible clerical of laboratory error.

Applicant Signature: _____Date:_____

Signature of Person Performing the Test:_____Date:_____

Check Company Working For: WISE ☐ LABOR SOURCE ☐ ONESOURCE ☐

Authorization of Treatment

Employer:_____
Employee Name:_____
Employee DOB:_____
Employee SSN:_____

Guarantor: 432 Magazine Street
Tupelo, MS 38802
662-680-5062

Protocol:

- Please submit all medical paperwork to fax# (662)841-9961
- Medical invoices should be mailed to **company checked above and guarantor address.**

Part of body affected for treatment: _____

Authorized by:_____

Phone:_____

Date:_____

PHARMACY INFORMATION

Employee listed below is authorized to received medication that has been prescribed by their treating physician, for their alleged work-related injury.

Select Company Working For: LABOR SOURCE ☐ ONESOURCE ☐

Printed Employee Name: _____

SSN: _____ DOB: _____ Date of Injury: _____

Pharmacy: __WALGREENS_____

Health Lift Help Line: ___(844) 328-2048_____

BIN: 020743 Member ID: _____ (SOCIAL SECURITY NUMBER)

GROUP NUMBER: PHARMACY GENERATED: _____ (WORK ADDRESS & PHONE NUMBER)

Authorized By:_____

Phone Number: _____

Date: _____

Employee is to give this complete authorization form to the pharmacy at the time they present them with their prescription that was given to them by the treating physician.

Check Company Working For: WISE ☐ LABOR SOURCE ☐ ONESOURCE ☐

Read the Following Statement Before Signing this Form.

By signing below, I certify that the information provided is true and correct to the best of my knowledge. I also certify that I understand that if I refuse medical treatment, services, and/or supplies provided by my Wise Staffing Group and its member companies (Wise Staffing Services, Inc., Labor Source, LLC., Onesource Staffing, LLC., and Resource Management Group, LLC.) or if I refuse employment suitable to any partial disability caused by the above injury, that this could lead to my termination and may jeopardize my insurance benefits.

Signature of Injured Employee: _____

Medical Records Release

I, _____ , authorize that my employer, anyone acting on their behalf including but not limited to, their insurance carrier, attorney or other representative, shall be permitted to examine and obtain copies of all hospital, medical, vocational, drug screen records, interview all doctors, rehabilitation professionals vendors regarding all matters relating to any issue relevant to my Workers' Compensation Claim.

A copy of this authorization is to be considered as an original for this purpose.

Signature of Injured Employee:_____ Today's Date:_____

Modified Duty Form

Check Company Working For: WISE ☐ LABOR SOURCE ☐ ONESOURCE ☐

Date: _____

Dear: (Employee Name): _____

Wise Staffing Group and its member companies (Wise Staffing Services, Inc., Labor Source, LLC., Onesource Staffing LLC., and Resource Management Group, LLC.) desires to provide our injured employees with the most expedient and quality medical care for their work-related injuries. We have developed a modified duty plan that will allow our injured workers to return to work on a modified duty status by making accommodation for work restrictions.

You have been advised by the doctor that you have been released to modified status as of _____. The letter serves as notice to you that modified duty is available as of _____ and you should report to work at (time) _____ am/pm on this date for your assignment.

_____ _____

Worksite Address

Failure to report will be considered an unexcused absence, and you will not be paid for the days missed. We feel a strong commitment to providing gainful employment to our injured workers during their recovery from work related injuries, and we would appreciate your cooperation. If you have any questions or concerns, call your Supervisor.

I accept modified Duty ☐ I decline modified duty ☐

Employee Signature: _____ Date: _____

☐ Employee is not present in office, offer made by **telephone** and employee declined modified duty. Form sent to employee via mail on (date)_____.
☐ Employee is not present in office, offer made by **telephone** and employee accepted modified duty.

Office Managers Signature: _____

Check Company Working For: WISE ☐ LABOR SOURCE ☐ ONESOURCE ☐

DECLINE OF MEDICAL TREATMENT OR OBSERVATION

Employee's Name: _____ Date Reported: _____

Date of Injury: _____ Time of Injury: _____

Supervisor: _____ Client /Location: _____

Witness(es): _____

Nature of Injury/Condition: _____

Description of Injury [Body Part(s) Injured]: _____

_____

Brief Narrative Description of the Incident: _____

_____

I, hereby acknowledge my declination of medical treatment and/or observation offered to me by _____ for the injury or illness reported on _____. I recognize that signing this declination does not necessarilyimpact my later eligibility for Workers' Compensation benefits as subject to statute and insurer review.

At this time, I acknowledge that my supervisor/employer, in good faith, has offered andmade available to me an opportunity to seek necessary medical treatment and/or observation.

At a later time, I may request from my employer, via my supervisor, a medical authorization to obtain medical treatment and/or observation for the above-describedinjury.

_____
Employee's Signature

_____
Date

_____
Employee Representative/Witness

INCIDENT REPORT

NON-WORK RELATED/NEAR MISS

Check Company Working For: WISE ☐ LABOR SOURCE ☐ ONESOURCE ☐

REPORTED BY: _____ **DATE OF REPORT**: _____

INCIDENT INFORMATION

INCIDENT TYPE: _____ DATE OF INCIDENT: _____

LOCATION: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

INCIDENT DESCRIPTION: _____

_____

_____

_____

_____

NAME OF WITNESSES:

_____

_____

ACTION TAKEN:

_____

_____

_____

_____