Workplace Incident/Injury

TAKE THE RIGHT STEPS

This packet contains all the information you need to report an injury and file a workers' compensation claim to ensure proper treatment, payment, and a safe return to work. If you have any questions, please contact the Claims Examiner listed below.

In emergency situations, injured workers should immediately notify their supervisor and seek treatment at the nearest medical facility.

1. **EMPLOYEE** should immediately notify their **SUPERVISOR/HR department** to determine the best course of treatment. If a workers' compensation claim will be filed (i.e., if the injury cannot be addressed with first aid), please follow the instructions below.

2. **EMPLOYEE & SUPERVISOR** must complete an Employee Incident Report through our website link within 24 hours. Print a copy of this packet and provide it to the injured worker. Review and follow the instructions noted at the top of the following forms:

   - Incident Report
   - Employee Acknowledgement of Workers' Compensation Policy
   - First Report of Injury
   - Authorization to Release Medical Information
   - Physician's Report of Work Ability

3. **EMPLOYEE** must follow up with their supervisor/risk department regarding any restrictions and return to work information provided by the physician. Please be sure to take the contact card provided for the Claims Examiner listed below to all treating facilities. This will inform the facility that all bills and correspondence generated from the claim should be submitted to:

Hilary Schille
Sheakley
Claims Examiner
One Sheakley Way
Cincinnati, OH 45246
Call/Text: 513.618.1411
Fax: 513.672.4511

4. **SUPERVISOR/HR department** must ensure that the post-accident procedures are being followed. Sheakley must be notified of the incident as soon as possible by completing and submitting all necessary forms. In the event that all forms cannot be completed at once please be sure to submit them upon completion to ACS.Claims@Sheakley.com

Upon receipt, a Workers' Compensation claim will be filed unless reported as incident only.

ACS ALTERNATIVE COMP SOLUTIONS

EMPLOYEE: COMPLETE, SIGN, AND GIVE TO SUPERVISOR/HR DEPARTMENT

SUPERVISOR/HR DEPARTMENT: ENSURE ALL FIELDS ARE COMPLETED & SUBMIT TO ACS.CLAIMS@SHEAKLEY.COM

EMPLOYEE ACKNOWLEDGEMENT OF WORKERS' COMPENSATION POLICY

I,_____(print name), hereby acknowledge my responsibility of the filing of a workers' compensation claim for the incident/injury date of_____.

I understand that these documents require full completion and must be returned to my supervisor or workers' compensation administrator as instructed as soon as possible in order for me to enter into Alternative Comp Solutions' workers compensation program.

I understand that I must comply with the rules and regulations set forth by the Bureau of Workers' Compensation and my employer.

I also understand that if I have any questions or concerns regarding my workers' compensation claim or process, I am accountable for asking my claims examiner for assistance.

_____ (signature) _____(date)

Hilary Schille
Claims Examiner
One Sheakley Way
Cincinnati, OH 45246
Call/Text: 513.618.1411
Fax: 513.672.4511

ACS ALTERNATIVE COMP SOLUTIONS

" Merging Talent with Opportunity"

Drug Screen Authorization for Urine Cups

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:_____

Reason for Testing: Pre-Employment Random Reasonable Suspicion / Cause Post Accident Other:_____

Read Temperature within (4) Minutes. Specimen within range: ☐ Yes, 90º - 100Fº ☐ No, record specimen temperature here_____

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:_____

*Revised 2.24

" Merging Talent with Opportunity"

Drug Screen Authorization for Oral Swabs

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:_____

Reason for Testing: Pre-Employment Random Reasonable Suspicion / Cause Post Accident Other:_____

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
Oxycodone (OXY)	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:_____

*Revised 3.21.23

EMPLOYEE: COMPLETE, SIGN AND GIVE TO SUPERVISOR/HR DEPARTMENT TO COPY. TAKE A COPY OF THIS FORM TO THE TREATMENT FACILITY

SUPERVISOR/HR DEPARTMENT: COPY FOR EMPLOYEE TO PROVIDE TO TREATMENT FACILITY AND SUBMIT A COPY TO ACS.CLAIMS@SHEAKLEY.COM

1. EMPLOYEE INFORMATION

LAST NAME, FIRST NAME, MIDDLE INITIAL	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX (CIRCLE ONE) M F
STREET ADDRESS		CITY, STATE, ZIP	JOB TITLE
EMAIL ADDRESS	WORK DAYS (CIRCLE ALL THAT APPLY) SU M TU W TH F SA		REGULAR WORK HOURS
HOME PHONE ( ) -		CELL PHONE ( ) -	
SIGNATURE		DATE	

2. INCIDENT INFORMATION

DATE OF INJURY/DISEASE	TIME OF INJURY	DATE LAST WORKED	DATE RETURNED TO WORK	DATE OF DEATH IF FATAL
PART(S) OF BODY INJURED		DATE OF HIRE	DATE EMPLOYER NOTIFIED	DATE OF FIRST TREATMENT
DESCRIPTION OF INJURY				
ACCIDENT LOCATION IF DIFFERENT FROM EMPLOYER				

3. TREATMENT INFORMATION

PHYSICIAN/HEALTH CARE PROVIDER NAME	TELEPHONE NUMBER ( ) -	FAX NUMBER ( ) -	DRUG TEST OBTAINED
STREET ADDRESS	CITY	STATE	ZIP CODE

4. EMPLOYER INFORMATION

EMPLOYER NAME	SENT FOR DRUG/ALCOHOL SCREEN? YES NO IF YES: LOCATION:	POLICY NUMBER
MAILING ADDRESS (STREET, CITY, STATE, ZIP)		TELEPHONE NUMBER ( ) -
SIGNATURE AND TITLE		DATE

5. WITNESS INFORMATION - USE ADDITIONAL PAGES IF NEEDED

NAME	STATEMENT DATE
DESCRIPTION OF INCIDENT	
NAME	STATEMENT DATE
DESCRIPTION OF INCIDENT	

ACS ALTERNATIVE COMP SOLUTIONS

EMPLOYEE: COMPLETE, SIGN, AND GIVE TO SUPERVISOR/HR DEPARTMENT

SUPERVISOR: ENSURE ALL FIELDS ARE COMPLETED & SUBMIT TO ACS.CLAIMS@SHEAKLEY.COM

Ohio | Bureau of Workers' Compensation

Authorization to Release Medical Information

Instructions

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

- Please print or type.
- 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.

C-101 - Authorization to Release Medical Information: Injured workers should use this form to authorize the release of medical records relative to their work-related injury(s). By signing this form, the injured worker authorizes medical providers who have rendered services relative to the injury to release information to BWC, the Industrial Commission, the employer, the managed care organization (MCO) or qualified health plan (QHP) and any authorized representatives. The form is intended to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), although BWC is exempt from HIPAA requirements.

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 (_____ _____) 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 immunohistochemical 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. _____

_____

EMPLOYEE: COMPLETE, SIGN, AND GIVE TO SUPERVISOR/HR DEPARTMENT

SUPERVISOR: ENSURE ALL FIELDS ARE COMPLETED & SUBMIT TO ACS.CLAIMS@SHEAKLEY.COM

Claimant's name: _____ Claim number: Pending

I, the above-named injured worker, understand I am allowing the following named physicians listed below to release to Sheakley, 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 dating back ten years prior to the injury. I understand I am authorizing the release of this information to the following to be used in the administering of my workers comp claim: Ohio BWC, the Industrial Commission of Ohio, the employer on the claim, the employers MCO or qualified health plan and authorized representatives. Also, by signing the medical release I authorize the representative the right to medical from the providers listed as well as access to any additional claims in the Ohio Bureau of Workers compensation system:

Injured Workers Signature:	Date:

Have you had treatment for an injury or chronic condition(s) for this body part(s) prior to this injury?
YES_____ NO_____

If you answered yes, please complete the rest of this form with the names of the providers with whom you treated.

Physician Name_____

Street Address_____

City: _____ State_____ Zip Code_____

Phone #:_____

Physician Name_____

Street Address_____

City: _____ State_____ Zip Code_____

Phone #:_____

Physician Name_____

Street Address_____

City: _____ State_____ Zip Code_____

Phone #:_____

Physician Name_____

Street Address_____

City: _____ State_____ Zip Code_____

Phone #:_____

ACS ALTERNATIVE COMP SOLUTIONS

PHYSICIAN, PLEASE READ

MODIFIED DUTY
RETURN TO WORK PROGRAM

The health and well-being of every employee is extremely important to us. Our ultimate goal is to return our injured employees to their original jobs. If an injured employee is unable to perform all of the primary functions of the original job, we will make every effort to provide a transitional work assignment that will meet the injured workers' capabilities. This could result in the employee being placed in a modified duty, offsite position. This service allows us to consider the ability to accommodate any possible restrictions the injured employee may have.

If you have any questions about restrictions and available light duty work, please contact:

Hilary Schille
Claims Examiner
One Sheakley Way
Cincinnati, OH 45246
Call/Text: 513.618.1411
Fax: 513.672.4511
Email: ACS.Claims@Sheakley.com

ACS ALTERNATIVE COMP SOLUTIONS

ACS ALTERNATIVE COMP SOLUTIONS

Workers' Compensation
PriorityRx Prescription Payment Authorization Form

*Please keep this Authorization Form on file with script for auditing purposes. *

Pharmacist:

This is a temporary workers' comp Rx payment authorization form.

Please contact the M. Joseph Medical Help Desk at 844-DME-AND-Rx (844-363-2637) prior to submitting prescription(s). If you have any questions or experience any issues, please contact M. Joseph Medical Help Desk at 844-DME- AND-Rx (844-363-2637).

Processing information

Processor: EHO (Employer Health Options)
Bin #'s: 004527 (most pharmacies use this number)
Envoy/WebMD = 003241
CVS Condor Code = 15721
Eckerd's/Rite Aid Condor Code = 2185

(These specific pharmacy chains require special numbers to transmit prescriptions. All major chains and most independent pharmacies accept this plan.)

Version: D.O

Patient Information

Last Name: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __
First Name: __ __ __ __ __ __ __ __ __ __ __ __
Group#: 81203 Sex: Male [ ] Female [ ]
ID#/ SS#: __ __ __ __ __ __ __ __ __
D.O.B.: __ __ / __ __ / __ __ __ __

Prior Authorization #: _____ (retain this # for future use)
Prior authorization # = DOI in YYMMDD format (Example: July 20, 2014 would be 140720)

Date Sent: _____

EMPLOYEE: COMPLETE, SIGN AND GIVE TO SUPERVISOR/HR DEPARTMENT TO COPY. TAKE A COPY OF THIS FORM TO THE TREATMENT FACILITY

SUPERVISOR/HR DEPARTMENT: COPY FOR EMPLOYEE TO PROVIDE TO TREATMENT FACILITY AND SUBMIT A COPY TO ACS.CLAIMS@SHEAKLEY.COM

Bureau of Workers' Compensation

First Report of Injury, Occupational Disease, or Death (FROI)

Submit the form to BWC in one of the following ways. **Online:** bwc.ohio.gov, **Fax:** 1-866-336-8352, **Mail:** BWC Mail Processing Center, Attn: Claims, 30 W. Spring St. Columbus, OH 43215
Note: If you work for a self-insuring employer, submit this form to your employer's workers' comp manager.

Injured worker information

First name, middle initial, last name	Date of injury/disease	Social Security number	Date of birth

Mailing address; add apartment number or P.O. Box, if applicable	City	State	ZIP code

Sex ☐ Male ☐ Female	Email address	Home phone number	Cell phone number

Employer name	Employer address	City	State	ZIP code

Was the injured worker hired through a temp agency? ☐ Yes ☐ No If yes, name of temp agency	Mark the days of the week you usually work ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat	Regular work hours (include a.m. p.m.) From To

Date hired	Job title	State where hired	State where supervised	Wage rate; $ per hour	Number of hours scheduled to work the week of this injury

Work number for call-offs (Number injured worker calls to reach supervisor)	Part(s) of body affected (For example: Left knee, right index finger)

Accident description (Describe the sequence of events that directly caused the injury or death.)	**Will the incident cause the injured worker to miss 8 or more days from work?** ☐ Yes ☐ No

Injured worker start time _____ ☐ am ☐ pm	Time of injury _____ ☐ am ☐ pm	Date employer notified	Was any part of a workday missed due to the injury? ☐ Yes ☐ No	Date last worked	If the injured worker has returned to work, provide the date.

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

Initial treatment date	Health-care office/Facility name	Treating physician/Provider name	Telephone number	Fax number

Health-care office/Facility street address	City	State	ZIP code

If the injury resulted in death, answer the following.
Date of death — Decedent's marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed — Decedent's number of dependents

To be completed by the injured worker

By signing this form, I:

- **Elect to only receive compensation, benefits, or both provided for in this claim under Ohio's workers' compensation laws.**
- **Understand, waive, and release my right to receive compensation and benefits under the workers' compensation laws of another state for the injury, occupational disease, or death resulting from an injury or occupational disease for which I am filing this claim.**
- **Confirm I have not received compensation and benefits under the workers' compensation laws of another state for this claim, and I will notify BWC immediately upon receiving any compensation or benefits from any source for this claim.**
- **Will not file and have not filed a claim in another state for the injury, occupational disease, or death resulting from an injury or occupational disease for which I am filing this claim.**

Furthermore, I understand that:

- Upon request, my treating providers may submit to BWC, my employer, my employer's managed care organization or qualified health plan, or their authorized representatives medical, psychological, psychiatric, or vocational documentation relating causally or historically to physical or mental injuries relevant to this claim and necessary for me to obtain medical services, benefits, or compensation.
- Proper administration of this claim may require BWC to review and share with the employers of record, their authorized representatives, or my authorized representative any information or record maintained in this claim, or in my previous or future claims.
- Information or records maintained in my previous or future claims may affect decisions made in this claim.
- Any person who obtains compensation or benefits from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false statements, or accepting compensation or benefits to which he or she is not entitled, is subject to felony criminal prosecution for fraud (Ohio Revised Code 2913.48).

I certify that I have read, understand, and agree to the above statements and the information contained on this form is true and accurate to the best of my knowledge.

Injured worker signature	Date

To be completed by the treating provider

Diagnosis(es)-narrative description including as appropriate, the location and body part, and ICD code(s). **Important:** If there is an injury, list the condition or disease, not the symptoms or exposure. For example, "sprain right knee" not "pain right knee", "toxic effect of ammonia" not "exposure to ammonia", "contusion to the head" not "headache".

Initial treatment date	Are the medical conditions you have listed above causally related to the reported work-related accident or occupational disease? ☐ Yes ☐ No Are you the physician of record? ☐ Yes ☐ No

Treating physician/Provider's name (Print)	Treating physician/Provider's signature	BWC provider number	Date

To be completed by the employer

Employer name	Employer county	Phone number	Fax number	Email address
Alternative Comp Solutions				

Employer policy number	Federal ID number	Injured worker is (Check box, if applicable.) ☐ Owner/Sole proprietor ☐ Partner ☐ Individual incorporated as a corporation
80033740		

For all employers: ☐ Certification – I certify the facts in this application are correct and valid. ☐ Rejection – I reject the validity of this claim for the reason(s) listed below.
For self-insuring employers only: ☐ Medical only ☐ Lost time
Clarification – I clarify and allow the claim for the condition(s) below.

Employer signature and title	Date

To be completed by the submitter if the form is completed by someone other than the injured worker, treating physician, or employer

Signature of person completing this form	Date

EMPLOYEE: GIVE TO PHYSICIAN TO COMPLETE AND RETURN TO SUPERVISOR/HR DEPARTMENT

SUPERVISOR/HR DEPARTMENT: UPON RECEIPT SUBMIT TO ACS.CLAIMS@SHEAKLEY.COM

Bureau of Workers' Compensation

Physician's Report of Work Ability (MEDCO-14)

Instructions

- Use this form to provide detailed information about the injured worker's ability to work. Add comments to Section 4 or attach additional information as necessary. BWC uses the information to support a request for temporary total compensation.
- The treating physician must submit this form each time they see the injured worker unless they:
  - Have been awarded permanent and total disability.
  - Have returned to work without restrictions within seven days of the injury.
  - Are being treated after the treating physician has released them to their former position of employment (i.e., full duty job) held on the date of injury without restrictions.
- While you may use an equivalent physician-generated document (e.g., office notes, treatment plan) to the MEDCO-14, it must contain, at a minimum, the required data elements. If you've previously submitted equivalent data, indicate the date of the report on the form (e.g., 5/15/2021, office note).

Note: Physician assistants and nurse practitioners may complete this form; however, they may only certify temporary disability for the first six weeks after the date of injury. Subsequent periods of temporary disability require a co-signature by the treating physician.

- Fax form to the managed care organization if the employer is state-fund or to the employer if self-insured.
- **Important:** Failure to provide complete information may delay compensation payments to the injured worker.

Injured worker name	Claim number	Date of injury

Date of *last* appointment/examination	Date of *this* appointment/examination	Date of *next* appointment/examination

1 Submission type (Select one of the options below.)

☐ Initial MEDCO-14. ***Proceed to Section 2.***
☐ Subsequent MEDCO-14, **no** changes ***Proceed to Section 6.***
☐ Subsequent MEDCO-14, **with changes.** Check the appropriate box "Reporting changes from the last evaluation" or "No changes" in each section.

2 Job description and work status ☐ Reporting changes from last evaluation ☐ No changes

- Have you reviewed the injured worker's job description? ☐ Yes ☐ No
  - **If yes,** who provided the job description ☐ Injured worker ☐ Employer ☐ MCO/BWC
- Does the injured worker have any physical or health restrictions **related to the allowed conditions in the claim** on the date of this exam? ☐ Yes ☐ No
  - **If yes,** are the restrictions: ☐ Permanent? ☐ Temporary?
  - **If no,** check the box to indicate the injured worker is released to return to full duty as of the date of this exam. ☐ ***Proceed to Section 6.***
- If there are restrictions, can the injured worker return to their full duty job held on the date of injury as of the date of this exam? ☐ Yes ☐ No
  - **If yes, *Proceed to Section 6.***
  - **If no,** provide date restrictions began ____/____/____ and estimated full duty return-to-work date ____/____/____. ***Proceed to Section 3.***

3 Disability information ☐ Reporting changes from last evaluation ☐ No changes

Complete the chart below for all **work-related allowed conditions being treated**.

Narrative description of the **work-related allowed condition**	Site/Location if applicable	ICD code	Is the condition preventing full duty release to the job injured worker held on the date of injury?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

List all other conditions that **impact treatment** of the conditions listed above (e.g., co-morbidities or not yet allowed conditions).

BWC-3914 (Rev. Sept. 18, 2023)
MEDCO-14

Bureau of Workers' Compensation

Physician's Report of Work Ability (MEDCO-14)

Instructions

- Use this form to provide detailed information about the injured worker's ability to work. Add comments to Section 4 or attach additional information as necessary. BWC uses the information to support a request for temporary total compensation.
- The treating physician must submit this form each time they see the injured worker unless they:
  - Have been awarded permanent and total disability.
  - Have returned to work without restrictions within seven days of the injury.
  - Are being treated after the treating physician has released them to their former position of employment (i.e., full duty job) held on the date of injury without restrictions.
- While you may use an equivalent physician-generated document (e.g., office notes, treatment plan) to the MEDCO-14, it must contain, at a minimum, the required data elements. If you've previously submitted equivalent data, indicate the date of the report on the form (e.g., 5/15/2021, office note).

Note: Physician assistants and nurse practitioners may complete this form; however, they may only certify temporary disability for the first six weeks after the date of injury. Subsequent periods of temporary disability require a co-signature by the treating physician.

- Fax form to the managed care organization if the employer is state-fund or to the employer if self-insured.
- **Important:** Failure to provide complete information may delay compensation payments to the injured worker.

Injured worker name	Claim number	Date of injury

Date of ***last*** appointment/examination	Date of ***this*** appointment/examination	Date of ***next*** appointment/examination

1 Submission type (Select one of the options below.)

☐ Initial MEDCO-14. ***Proceed to Section 2.***
☐ Subsequent MEDCO-14, no changes ***Proceed to Section 6.***
☐ Subsequent MEDCO-14, **with changes.** Check the appropriate box "Reporting changes from the last evaluation" or "No changes" in each section.

2 Job description and work status ☐ Reporting changes from last evaluation ☐ No changes

- Have you reviewed the injured worker's job description? ☐ Yes ☐ No
  - **If yes,** who provided the job description ☐ Injured worker ☐ Employer ☐ MCO/BWC
- Does the injured worker have any physical or health restrictions **related to the allowed conditions in the claim** on the date of this exam? ☐ Yes ☐ No
  - **If yes,** are the restrictions: ☐ Permanent? ☐ Temporary?
  - **If no,** check the box to indicate the injured worker is released to return to full duty as of the date of this exam. ☐ ***Proceed to Section 6.***
- If there are restrictions, can the injured worker return to their full duty job held on the date of injury as of the date of this exam? ☐ Yes ☐ No
  - **If yes,** ***Proceed to Section 6.***
  - **If no,** provide date restrictions began ____/____/____ and estimated full duty return-to-work date ____/____/____. ***Proceed to Section 3.***

3 Disability information ☐ Reporting changes from last evaluation ☐ No changes

Complete the chart below for all **work-related allowed conditions being treated**.

Narrative description of the **work-related allowed condition**	Site/Location if applicable	ICD code	Is the condition preventing full duty release to the job injured worker held on the date of injury?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

List all other conditions that **impact treatment** of the conditions listed above (e.g., co-morbidities or not yet allowed conditions).

BWC-3914 (Rev. Sept. 18, 2023)
MEDCO-14