Policy Title	Workers' Compensation
Effective Date	2-1-2021
Approved by	City Manager

1. Statement of Purpose

A. The safety of our employees will always be a foremost concern. To that end, the City of Trenton (the "City") considers serious all claims of on-the-job injuries. Any employee injured at work should be provided with prompt treatment and support. The City has a relationship with Premier Occupational Health ("Premier") to ensure that we provide that treatment as promptly as possible, while complying with the State of Ohio Bureau of Worker's Compensation ("BWC") Plan Program procedures and requirements.

B. The following pages outline the procedures that should be followed to get prompt treatment for on-the-job injuries. Also included is a **REFERRAL FROM EMPLOYER** form that, whenever possible, should be filled out by your supervisor and taken by you to Premier to get treatment. **Note that in an emergency, you don't have to fill out a 'Referral' form.**

C. It is strongly recommended that you go to Premier for your treatment to minimize any problems with the BWC regarding payment. Premier will submit all paperwork to the BWC on your behalf. If you go to your own doctor or emergency room, it will be your responsibility to make sure that your doctor is aware that this is an on-the-job injury so that his or her staff can fill out the appropriate forms.

City of Trenton

Workplace Injury:

Simplifying the Process

Employee

1. Injured Worker immediately notifies supervisor.
2. Injured Worker completes highlighted section (Injured Worker & Injury Info) of the "BWC First Report of Injury" as completely as possible.
3. This Injury Reporting Packet contains a **CareWorks ID card. Keep this card and show it to every medical provider treating your work-related injury.**
4. Seek treatment from a CareWorks network provider. (Most in this area are in network.)
5. Once at the medical facility, request drug and alcohol screening.
6. Return Injury and Illness Report (301P) paperwork to the BWC staff representative as soon as possible.

Supervisor/Department Head

Complete the "BWC Injury and Illness Incident Report" as completely as possible and return to the BWC staff representative listed below.

For Additional Information

Please contact Sharon Leichman at 513.988.6304 x150
or via email at sleichman@ci.trenton.oh.us

Trenton

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
City of Trenton

Mailing address (number and street, city or town, state, ZIP code and county)
11 E State St Trenton, OH 45067

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 **30905602-0** | Check if ☐ Employer is self-insuring ☐ Injured worker is owner/partner/member of firm

Telephone number **(513) 988-6304** | Fax number ( ) | E-mail address | Federal ID number **31-6001089** | Manual number **9431-000**

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

FOR WORKERS' COMPENSATION INJURY MANAGEMENT ONLY

BWC Policy # 30905602-0

Attention Provider
You are required by Rule 4123-6-028
to report work-related injuries within 24 hours.

Attention Employee
This card is for information purposes only.
This card is not a guarantee of coverage.

Send Medical Bills to:
CareWorks
P.O. Box 182726
Columbus, Ohio 43218-2726

Customer Service: 1-888-627-7586
Injury Reporting Fax: 1-888-711-9284
Prior Authorization Fax: 1-888-627-0074
Email: CWmedical@careworks.com
Internet : www.careworks.com

UR AC
ACCREDITED
CASE MANAGEMENT

For prescription drug information, contact 1-800-OHIOBWC or visit www.bwc.ohio.gov.

State of Ohio — Public Employment Risk Reduction Program — Form 301P (Rev. 01/2015)

Injury and Illness Incident Report

ATTENTION: This form contains information relating to employee health. Please use it in a manner that protects the confidentiality of employees while also allowing for use of the information for occupational safety and health purposes.

Ohio | Bureau of Workers' Compensation
Division of Safety & Hygiene, PERRP
13430 Yarmouth Dr., Pickerington, OH 43147

This *Injury and Illness Incident Report* is one of the first forms you must fill out when a recordable work-related injury or illness occurs. Together with the *Log of Work-Related injuries and Illnesses* (300P) and the accompanying Summary (300AP), these forms help you and PERRP develop a picture of the extent and severity of work-related incidents. You must complete this form or an equivalent ***within six calendar days*** after receiving information that a recordable work-related injury or illness has occurred.

BWC's *First Report of an Injury, Occupational Disease or Death* (FROI) is an acceptable substitute. To be considered an equivalent, the substitute must contain all of the information on this form. You must keep this form on file for five years following the year to which it pertains.

If you need additional copies of this form, you may photocopy (or print) and use as many as you need.

ATTENTION: All **Ohio public employers** must complete this form (or an equivalent). This includes the State of Ohio and its instrumentalities; and "any political subdivisions and their instrumentalities, including any county, county or state hospital, municipal corporation, city, village, township, park district, school district, state institutions of higher learning, public or special district, state agency, authority, commission or board" as defined in Ohio Revised Code 4167.01.

Completed by _____

Title _____

Phone _____ Date _____

Information about the employee

1) Full name _____

2) Street _____

City _____ State _____ Zip code _____

3) Date of birth _____

4) Date hired _____

5) Job title _____

6) ☐Male ☐Female

Information about the physician or other health-care professional

7) Name of physician, other health-care professional or first-aid provider

_____

8) If treatment was given away from the work site, where was it given?

Facility _____

Street _____

City _____ State _____ Zip code _____

9) Was employee treated in an emergency room?
☐Yes ☐No

10) Was employee hospitalized overnight as an in-patient?
☐Yes ☐No

11) Did the employee receive treatment classified as first aid at the work site or hospital?
☐Yes ☐No

Information about the case

12) Case number from the Log _____ (Transfer the case number from the Log after you record the case.)

13) Date of injury or illness _____

14) Time employee began work _____ (AM/PM)

15) Time of event _____ (AM/PM) ☐Check if time cannot be determined.

16) **What was the employee doing just before the incident occurred?** Describe the activity, as well as the tools, equipment or material the employee was using. Be specific. (Examples: climbing a ladder while carrying roofing materials; spraying chlorine from hand sprayer; daily computer key-entry.)

17) **What happened?** Tell us how the injury occurred. (Examples: when ladder slipped on wet floor, worker fell 20 feet; worker was sprayed with chlorine when gasket broke during replacement; worker developed soreness in wrist over time.)

18) **What was the injury or illness?** Tell us the part of the body that was affected and how it was affected; be more specific than just using the words "hurt," "pain" or "sore." (Examples: strained lower back; chemical burn, right hand; carpal tunnel syndrome, left wrist.)

19) **What object or substance directly harmed the employee?** (Examples: concrete floor; chlorine; radial arm saw.) If this question does not apply to the incident, leave it blank.

20) **If the employee died, when did death occur?** Date of death _____