EMPLOYEE'S REPORT OF INCIDENT AND INJURY
PLEASE PRINT IN INK To be completed by Employee

Employer: Cleveland Heights-University Heights City School District 31805751-0

Name________________________________ Social Sec. No.________________________________
Home Address________________________________ Birth Date______________ Sex: ☐ Male ☐ Female
City/State/Zip________________________________ Telephone: ( )________________________

Date of injury **or** onset of symptoms________________________ Time______________ ☐ am ☐ pm
Described what caused the injury/symptoms, what you were doing **just before** the incident, and what you did **after** the incident (if you need more space, write on the back of this form). **Be specific - name any objects or substances involved:**______________

Did anyone see you get hurt? ☐ Yes ☐ No If yes, who?________________________
Did you report this incident to anyone? ☐ Yes ☐ No If not, why not?________________________
If yes, to whom did you report it?______________________ Title/Position______________ When?__________

What part(s) of your body was/were affected? (BE SPECIFIC: for example, right elbow, left knee, right index finger):

What type of injury did you experience? (BE SPECIFIC: for example, bruise, scrape, laceration, pull)__________________

Was any first aid provided at the scene? ☐ Yes ☐ No If yes, describe:________________________
Did you seek other medical treatment? ☐ Yes ☐ No If yes, when?________________________
Where?________________________ If treatment was not sought immediately, explain why: __________

Is this an aggravation of a previous injury/symptom? ☐ Yes ☐ No If yes, when were you last treated for the previous injury?
________________________ By whom or where?________________________
Have you ever had a similar injury? ☐ Yes ☐ No If yes, describe other injury:________________________

Medical Release

Under current workers' compensation provisions, the employer is entitled to a signed medical release

I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to **disclose such information** to my employer, my employer's managed care organization, or to my employer's designated representative, **CompManagement, Inc., a Sedgwick CMS company.** A copy of this form will serve as the original.

Employee Name (print)________________________________

Employee Signature________________________________ Date (required)________________________

STATEMENT OF WITNESS TO ACCIDENT

Employer: Cleveland Heights – University Heights City School District 31805751-0

I. INCIDENT IDENTIFICATION INFORMATION

Name of employee alleging incident____ Shift_________________________

Occupation____ Department__________________________________

II. WITNESS STATEMENT

Your name has been given as a witness to an incident alleged by the above individual. Through your cooperation, information can be obtained to complete the investigation of this incident. Therefore, it will be appreciated if you will answer each of the following questions and promptly return your completed statement.

Your name____ Your occupation______________________________

Your address____ Your telephone number ( ) ______ - ________
____

Did you see an accident involving the above employee? ☐ Yes ☐ No

If not, how did you learn about the accident?____
____

If you did see an accident occur: Date of accident___________________ Time of accident__________ ☐am ☐pm

Describe what you saw: ____
____
____
____
____
____
____

____ ____ ______________________
Your signature Please print your name Date

State of Ohio §

County of _________________________ §

Before me, a Notary Public in and for said state, personally appeared the above named who acknowledged before me that he/she did sign the foregoing instrument and that the same is his/her free act and deed.

In testimony whereof, I have hereunto affixed my name and official seal at ______________________, Ohio this ____________________ day of ____________________, 19______.

(SEAL) **(signed)____**

Name (printed or typed)______________________________________

Notary Public, State of Ohio

My Commission Expires_____________________(date)

SUPERVISOR'S INVESTIGATION REPORT

Employer: Cleveland Heights – University Heights City School District 31805751-0
Employee Name:_____________________________________ Soc. Sec. #_______________________________
Date of Injury:_______________________________________

Was an investigation completed concerning the circumstances of this injury? ☐ Yes ☐ No

Were there any witnesses to this injury? ☐ Yes ☐ No
If yes, witness statements should be attached.

Was the injury a result of horseplay? Under the influence of drugs, or purposely self-inflicted? If yes, please specify: ☐ Yes ☐ No

____
____
____

Has there been any recent disciplinary action taken against this employee? ☐ Yes ☐ No
If yes, please describe (and attach any written documentation):

____
____

Has the employee missed any work previously due to similar industrial or non -industrial conditions? If so, when?____ ☐ Yes ☐ No

What preventive action measures do you recommend?____
____
____

Has the employee submitted medical documentation for the injury? ☐ Yes ☐ No
If so, please attach.

If known, please provide us with the name, address and telephone number of the attending physician:

____
____
____
____

Has the employee returned to work? ☐ Yes ☐ No
Last day worked___________________ Returned to work__________________

If not, what is the current estimated date of return?_______________________________

With the information you have, would you recommend the claim be accepted? ☐ Yes ☐ No
If no, why?____
____

_______________________________ _______________________________ _______________________________
Employer's signature Title Date

PLEASE ATTACH COMPLETED INCIDENT REPORTS, WITNESS STATEMENTS AND ANY ACCUMULATED MEDICAL BILLS AND INFORMATION. ADDITIONAL COMMENTS MAY BE NOTED ON THE REVERSE SIDE.

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

2

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.

☐ 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

3

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

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

8

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.

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 – –

Bureau of Workers' Compensation

Instructions for Completing the Physician's Report of Work Ability

This form provides important information about the injured worker's ability to work.

- The treating physician must submit this form each time he/she sees the worker unless the worker has been awarded permanent and total disability, or has been previously released to the worker's former position without restrictions.
- Please complete this form and provide a copy to the worker during the worker's office visit. Fax a copy to the appropriate managed care organization (MCO) or to the worker's employer if that employer is self-insured.
- This form or an equivalent physician-generated document may support a request for temporary total compensation. The equivalent document must contain, at a minimum, the data elements required on this form. If equivalent data elements have previously been submitted and remain the same, please indicate the name of the report that reflects the worker's current condition, e.g. 5/18/11 office note.
- You may attach additional medical documentation such as diagnostic test results and a treatment plan to this form.
- Failure to provide complete detailed information may delay or suspend compensation payments to the worker.

Instructions

Injured worker progress section: Please indicate how the worker is progressing. If a MEDCO-14 was previously completed and there are no changed circumstances to report, you may indicate such in the designated area. If there have been any changed circumstances, including changes in the period of temporary total disability or release with restrictions, you must provide updates by completing the appropriate areas indicated.

Work status section: If you do not have a copy of the worker's job description, BWC or the MCO can help secure one. "Former position of employment" means the job duties performed in the position the worker held when injured. Checking:

- The first box indicates that from a medical perspective the worker cannot return to the former position of employment (i.e. job duties required or performed in the position held when he/she was injured);
- The second box indicates the worker can return to employment with restrictions. This could include portions of the worker's previous duties or other duties not previously a part of his or her former position of employment;
- The third box indicates the worker can return to the former position of employment (i.e. job duties required or performed in the position held when he/she was injured.) The ability to return to the former position of employment means that the worker can perform the job duties with either the employer of record or with another employer.

Injured worker's capabilities section: BWC will use this information to help facilitate the worker's return to work. Complete this section as accurately and thoroughly as possible. The following definitions apply to the Lifting/carrying, Pushing/pulling, Activity and Driving sections and are percentages as they relate to an eight-hour workday:

- Never – 0 percent;
- Occasionally – 1 percent to 33 percent, four to six repetitions per hour;
- Frequently – 34 percent to 66 percent, six to 12 repetitions per hour;
- Continuously – 67 percent to 100 percent, greater than 12 repetitions per hour.

Only providers treating the worker for allowed psychological conditions should complete the portion labeled "Degree of functional impairment based on allowed psychological conditions only."

Disability period information section: Furnish the narrative description of the diagnosis(s), site/location, if applicable, and ICD code for the conditions being treated due to the work-related injury. For each condition, indicate whether or not the condition is causing the temporary total disability.

Clinical findings section: Provide medical rationale for the delay in the worker's recovery and the barriers to return to work.

Maximum medical improvement (MMI) section: Please provide the MMI date or explain why the worker has not reached MMI. Provide the proposed treatment plan including estimated duration.

Vocational rehabilitation section: If the worker is not a candidate for vocational rehabilitation, please explain and recommend actions to help the worker return to employment.

Treating physician's signature section: Sign and date this form. Your signature indicates you have answered the questions as truthfully and completely as possible.

For more information or assistance

Please contact your local BWC customer service office, or call 1-800-OHIOBWC. You can obtain BWC forms at ohiobwc.com, at all BWC customer service offices, or by calling 1-800-OHIOBWC and listening to the options to reach a BWC customer service representative.