**CITY OF MACEDONIA**
**HUMAN RESOURCES DEPARTMENT**
9691 VALLEY VIEW ROAD
MACEDONIA, OH 44056
Phone: 330.468-8353
Fax: 330.468-8354

# Workers' Compensation

## Employee Responsibilities

1. **REPORT** the injury immediately (same shift/day) to your Supervisor and HR.

2. **SEEK** immediate medical attention, if necessary. Your Supervisor will provide you with an ***Injured Workers' Packet*** informing you of your rights and responsibilities. The packet will include important information and forms for you and the healthcare provider(s). If reasonably possible, bring this packet with you to the medical facility.

3. **COMPLETE** the ***Employee's Report of Incident and/or Injury*** & ***Authorization to Release Medical Information*** as soon as reasonably possible and at minimum before the close of the shift/day the incident or injury occurred.

4. **PRESENT** your ***Ohio Comp Identification Card*** (included inside the injured workers' packet – this is not your Healthcare coverage i.d. through your employer), also present the ***First Report of Injury*** (FROI) to the medical provider. The medical provider will forward the completed medical forms to Ohio Comp within 24 hours of being treated by **fax: 1-888.644-7339.**

5. **SUBMIT** all injury related paperwork to your Supervisor and HR during the shift/day the incident/injury occurred.

6. **FOLLOW** treatment instructions as defined by your medical provider.

7. **COMMUNICATE** your treatment plan with your Supervisor as well as Ohio Comp MCO. You may also direct any questions to, Ohio Comp 888-644-6266. Ohio Comp is a Managed Care Organization and they medically manage the workers' compensation claims for injured employees.

8. **REMAIN INFORMED** these are available resources should you have questions;

a) BWC website : https://www.bwc.ohio.gov/
b) City of Macedonia Human Resources website : http://www.macedonia.oh.us/human-resouces

# Injury reporting made easy!

## Injured employee steps:

**1** Immediately notify your employer of the injury.

**2** Seek medical treatment from the nearest medical facility. A BWC-certified health-care provider must provide medical services after the initial treatment.

**3** Show the 1-888-OHIOCOMP ID card to all medical providers treating your injury.

**4** Complete the BWC *First Report of Injury* (FROI) form and any accident report that may be required by your employer.

## Employer steps:

**1** Complete the employer portion of BWC's *First Report of Injury* (FROI) form.

**2** Fax the completed form to 1-888-OHIOCOMP at 1-888-644-7339.

**3** Report the injury by phone to 1-888-OHIOCOMP at 1-888-644-6266 or 216-426-0646.

In an emergency, immediately notify your employer and seek treatment at the nearest medical facility. A BWC-certified health-care provider must provide medical services after the initial treatment. **Call 1-888-OHIOCOMP if you need help locating a BWC-certified medical provider.**

**INJURED WORKER IDENTIFICATION CARD**

Please present to your medical provider when seeking initial medical treatment.

**WORKERS' COMPENSATION IDENTIFICATION CARD**

**Employer Name:** CITY OF MACEDONIA

**Employer Risk/Policy No:** 37705802

**First Report of Injury • Case Management Billing Questions** 1-888-644-6266

# Injured at work?

## WHAT TO DO IF YOU ARE INJURED ON THE JOB:

- **In case of medical emergency seek immediate treatment at the nearest medical facility.**
- Notify your supervisor immediately and assist in filing a First Report of Injury report.
- Obtain an injury packet from your supervisor.
- When seeking treatment, please let the medical provider know that 1-888-OHIOCOMP is your MCO and present your 1-888-OHIOCOMP ID card.

**ALERT!**

- You must receive treatment from a BWC certified medical provider or your medical treatment may not be covered unless it is emergency medical care.

**City of Macedonia**

Contact your supervisor or HR with any questions.

For information about medical treatment contact:
**1-888-OHIOCOMP**
Managed Care Organization
1-888-644-6266
www.1-888-OHIOCOMP.com

## CITY OF MACEDONIA PREFERRED PROVIDERS:

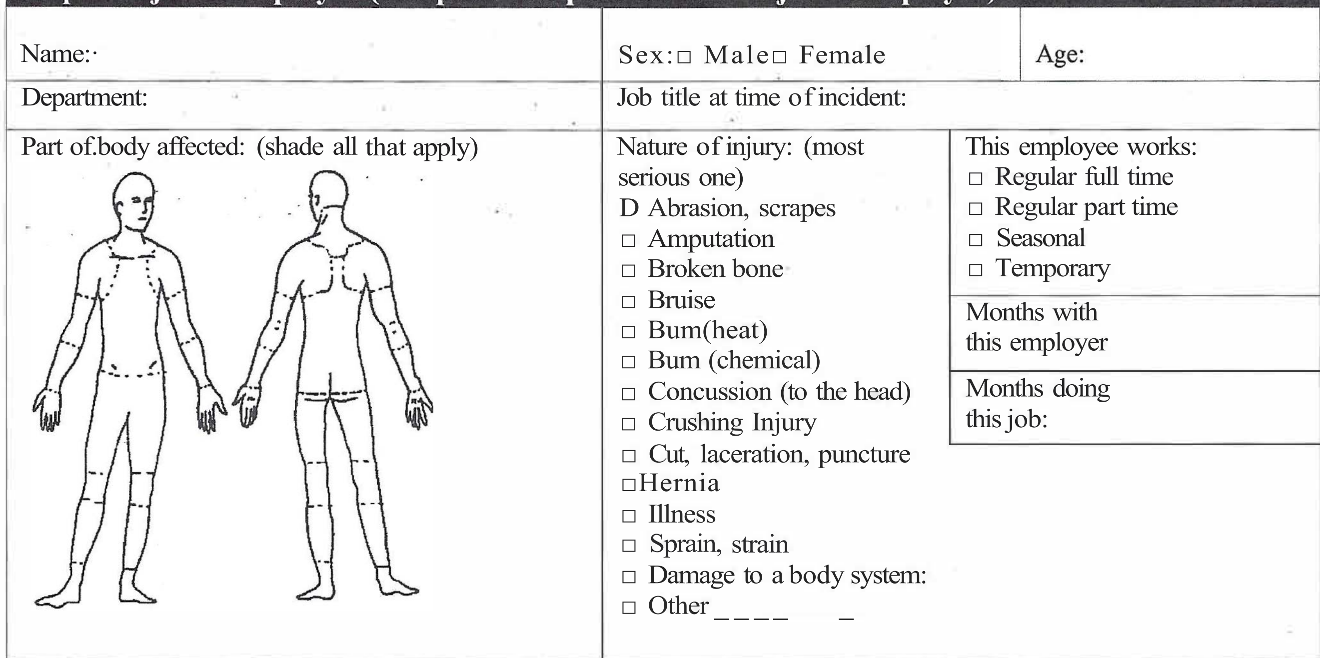
| | | | |
|---|---|---|---|
| **University Hospital Occupational Medicine** | 3619 Park East Drive<br>Suite 205<br>Beachwood, OH 44122 | **216-765-9781** | Daily<br>7:30 am-4:00pm |
| **For severe injuries and after hours:** | | | |
| **Ahuja Medical Center Emergency Room** | 3999 Richmond Road<br>Brecksville, OH 44122 | **216-593-5500** | 24 hours, daily |

# Employee Accident/Incident Investigation Report

**Instructions:** Complete this form as soon as possible after an incident that results in serious injury or illness. (Optional: Use to investigate a minor injury or near miss that *could have resulted in a serious injury or illness.)*

| | |
|---|---|
| This is a report of a: □ Death □ Lost Time □ Dr. Visit Only □ First Aid Only □ NearMiss<br>Did you seek Treatment: □ Yes □ No If Yes, Where: ___________________________ | |
| Date of incident:<br>Time of incedent: | This report is made by: □ Employee □ Supervisor □ Team □ Other________ |

## Step 1: Injured employee (complete this part for each injured employee)



| | | |
|---|---|---|
| Name: | Sex: □ Male □ Female | Age: |
| Department: | Job title at time of incident: | |
| Part of body affected: (shade all that apply) | Nature of injury: (most serious one)<br>D Abrasion, scrapes<br>□ Amputation<br>□ Broken bone<br>□ Bruise<br>□ Bum(heat)<br>□ Bum (chemical)<br>□ Concussion (to the head)<br>□ Crushing Injury<br>□ Cut, laceration, puncture<br>□ Hernia<br>□ Illness<br>□ Sprain, strain<br>□ Damage to a body system:<br>□ Other ____ _ | This employee works:<br>□ Regular full time<br>□ Regular part time<br>□ Seasonal<br>□ Temporary<br>Months with this employer<br>Months doing this job: |

## Step 2: Describe the incident

| | |
|---|---|
| Exact location of the incident: | Exact time: |
| What part of employee's workday? □ Entering or leaving work □ Doing normal work activities □ During meal period □ During break □ Working overtime □ Other_________ | |
| Names of witnesses (if any): | |

| **Number of attachments:** | Written witness statements: | Photographs: | Maps / drawings: |
|---|---|---|---|

What personal protective equipment was being used (if any)?

Describe, step-by-step the events that led up to the injury. Include names of any machines, parts, objects, tools, materials and other important details.

Description continued on attached sheets: □

## Step 3: Why did the incident happen?

Unsafe workplace conditions: (Check all that apply)
- □ Inadequate guard
- □ Unguarded hazard
- □ Safety device is defective
- □ Tool or equipment defective
- □ Workstation layout is hazardous
- □ Unsafe lighting
- □ Unsafe ventilation
- □ Lack of needed personal protective equipment
- □ Lack of appropriate equipment / tools
- □ Unsafe clothing
- □ No training or insufficient training
- □Other: _____________ _

Unsafe acts by people: (Check all that apply)
- □ Operating without permission
- □ Operating at unsafe speed
- □ Servicing equipment that has power to it
- □ Making a safety device inoperative
- □ Using defective equipment
- □ Using equipment in an unapproved way
- □ Unsafe lifting
- □ Taking an unsafe position or posture
- □ Distraction, teasing, horseplay
- □ Failure to wear personal protective equipment
- □ Failure to use the available equipment/ tools
- □Other: _______________ _

Why did the unsafe conditions exist?

Why did the unsafe acts occur?

Is there a reward (such as "the job can be done more quickly", or "the product is less likely to be damaged") that may have encouraged the unsafe conditions or acts? □ Yes □ No

If yes, describe:

Were the unsafe acts or conditions reported prior to the incident? □ Yes □ No

Have there been similar incidents or near misses prior to this one? □ Yes □ No

## Step 4: How can future incidents be prevented?

**What changes do you suggest to prevent this incident/near miss from happening again?**

□ Stop this activity o Guard the hazard □Traintheemployee(s) □ Train thesupervisor(s)

□ Redesign task steps o Redesign work station □ Write a new policy/rule □ Enforce existing policy

□ Routinely inspect for the hazard o Personal Protective Equipment o Other: ________ _

What should be (or has been) done to carry out the suggestion(s) checked above?

Description continued on attached sheets: □

## Step 5: Who completed and reviewed this form? (Please Print)

| Written by:<br>Department: | Title:<br>Date: |
|---|---|
| Names of investigation team members: | |
| Reviewed by: | Title:<br>Date: |

## Supervisor's Accident Investigation Form

Name of Injured Person ______________________ _

Date of Birth. ______ _ Telephone Number ________ _

Address ____________________________ _

City ____________ _ State __ _ Zip ____ _

(Circle one) Male Female

What part of the body was injured? Describe in detail. ___________________ _

_______________________________________________________________

What was the nature of the injury? Describe in detail. ___________________ _

_______________________________________________________________

_______________________________________________________________

Describe fully how the accident happened? What was employee doing prior to the event? What equipment, tools being using? _____________________________ _

_______________________________________________________________

_______________________________________________________________

Names of all witnesses:

______________________________ ______________________________

______________________________ ______________________________

Date of Event _________ _ Time of Event ______________ _

Exact location of event: _______________________________ _

What caused the event? _______________________________________________

_______________________________________________________________

_______________________________________________________________

Were safety regulations in place and used? If not, what was wrong? ______________ _

_______________________________________________________________

Employee went to doctor/hospital? Doctor's Name ____________________ _

Hospital Name ___________________ _

Recommended preventive action to take in the future to prevent reoccurrence.

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

_________________ __________

Supervisor Signature Date

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9691 VALLEYVIEW ROAD
MACEDONIA.OHIO 44056
Phone: 330.468-8353
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# CITY OF MACEDONIA
# Authorization to Release Medical Information

I hereby authorize any healthcare provider (person or facility) that attends, treats or examines me to release all medical, chiropractic, psychological and/or psychiatric information (excluding psychotherapy notes) that is causally or historically related to my workers' compensation claim, to my employer, City of Macedonia, and its representatives.

In addition to the above, I understand and agree to the following:

- I understand I am authorizing the release of this information to my employer, the Ohio Bureau of Workers' Compensation (BWC), the Industrial Commission of Ohio; 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 person and/or entities for use in administering my workers' compensation claim.
- The authorization to release medical, chiropractic, psychological and/or psychiatric information shall remain in effect for as long as my worker's 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. My decision to revoke this authorization will be effective, except in a case that a healthcare provider already has relied on my authorization and released information.
- I understand the provider (s) 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 re-disclosed by them and may no longer be protected by the federal privacy requirements. I understand such re-disclosures may include but are not limited to the following:
    - A copy of the medical information the employer receives may be forwarded to the 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.

Date: ________________ Signature: ________________________

SSN: XXX-XX-__________ Print Name: _______________________

Date of Birth: ___________

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

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.

policy number 377 | **Check if** ☐ Employer is self-insuring ☐ Injured worker is owner/partner/member of firm

e number | Fax number ( ) | E-mail address | Federal ID number | Manual number

loyee treated in an emergency room? ☐ Yes ☐ No | Was employee hospitalized overnight as an inpatient? ☐ Yes ☐ No

nt was given away from work site, provide the facility name, street address, city, state and ZIP code

**fication -** The employer es that the facts in this cation 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**

signature and title | Date | OSHA case number



This form meets OSHA 301 requirements

| Bureau of Workers' Compensation

# Physician's Report of Work Ability

| Injured worker name | | | Claim number |
|---|---|---|---|
| Date of injury | Date of last appointment/examination | Date of this appointment/examination | Date of next appointment/examination |

## MEDCO-14 submission (Select one of the options below.)

**1**

☐ I have never completed a MEDCO-14. ***Proceed to section 2.***
☐ I have previously completed a MEDCO-14, and all of the information remains the same. ***Proceed to and complete section 8.***
☐ I have previously completed a MEDCO-14, and I am providing updates appropriately checking Yes or No on each section.

## Employment/Occupation (Complete this section and proceed to section 3.) (Updates Yes ☐ No ☐)

**2**

Have you reviewed the description of the injured worker's job held on the date of injury (former position of employment)? Yes ☐ No ☐
**If yes** - please indicate who (select all sources) provided the job description ☐ Injured worker ☐ Employer ☐ MCO ☐ BWC

## Work status/Injured worker's capabilities (Updates Yes ☐ No ☐)

**3A**

Does the injured worker have any physical or health restrictions related to allowed conditions in the claim? Yes ☐ No ☐
**If yes,** are the restrictions: ☐ Permanent ☐ Temporary ***Proceed to section 3B.***
**If no**, please check the box to indicate the injured worker is released to work as of the date of this exam. ☐ ***Proceed to section 8.***

**3B**

If there are restrictions, can the injured worker return to the full duties of his/her job held on the date of injury (former position of employment)? Yes ☐ No ☐
**If yes,** please check the box to indicate that the injured worker is released to work as of the date of this exam. ☐ ***Proceed to section 8.***
**If no,** please indicate when the injured worker could not do the job held on the date of injury for this period of restricted duty.
Date:_____/_____/_____.

Please estimate when the injured worker should be able to return to the job held on the date of injury for this period of restricted duty.
Date:_____/_____/_____. **Proceed to section 3C.**

**3C**

**Please indicate which of the activities listed below the injured worker can perform (even if the response to 3B is No.)**
If the injured worker is not released to the former position of employment but may return to available and appropriate work with restrictions, please indicate the possible return to work date: ____/_____/_____.
The injured worker can perform simple grasping with: ☐ Left hand ☐ Right hand ☐ Both
The injured worker can perform repetitive wrist motion with: ☐ Left hand ☐ Right hand ☐ Both
The injured worker's dominant hand is: ☐ Left ☐ Right
The injured worker can perform repetitive actions to operate foot controls or motor vehicles with: ☐ Left foot ☐ Right foot ☐ Both
If the injured worker is taking prescribed medications for the allowed conditions in this claim, can the injured worker safely:
*Operate heavy machinery: ☐ Yes ☐ No *Drive: ☐ Yes ☐ No **Perform other critical job tasks as defined by any source listed above in section 2:* ☐ Yes ☐ No

| 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. | | | | | 0 to 25 lbs. | | | | |
| Bend | | | | | Reach above shoulder | | | | | 11 - 20 lbs. | | | | | 26 to 40 lbs. | | | | |
| Squat/kneel | | | | | Type/keyboard | | | | | 21 - 40 lbs. | | | | | 41 to 60 lbs. | | | | |
| Twist/turn | | | | | Work with cold substances | | | | | 41 - 60 lbs. | | | | | 61 to 100 lbs. | | | | |
| Climb | | | | | Work with hot substances | | | | | 61 - 100 lbs. | | | | | 100 + lbs. | | | | |

How many total hours can the injured worker work: _____ per week _____ per day?
In an eight-hour workday, how many total hours can the injured worker: Sit: ____ hours ☐ Continuously ☐ With break
Walk: ____ hours ☐ Continuously ☐ With break Stand: ____ hours ☐ Continuously ☐ With break
Does the injured worker have any functional restrictions based only on allowed psychological conditions? ☐ Yes ☐ No If Yes, please describe in space provided below. Note: If Yes is indicated please reference the MEDCO-16 as needed.
Additionally, in this space, please provide any additional information addressing the injured worker's capabilities and/or job accommodations which may not be addressed above. ____________________________________________

____________________________________________

____________________________________________

____________________________________________

____________________________________________

***Proceed to section 4.***

| Injured worker name | Claim number | Date of injury |
|---|---|---|
| | | |

## Disability information (If 3B above is "NO" or dates updated - all 4A fields, including site/location if applicable must be completed) (Updates Yes ☐ No ☐)

**4A** Complete the chart below and furnish the narrative description of the diagnosis(es), site/location, if applicable, and International Classification of Diseases (ICD) code(s) for the condition(s) being treated due to the work-related injury/disease. Please indicate if the condition is preventing the injured worker from returning to job duties he/she held on the date of injury.

| 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 ☐ |

**4B** List all other relevant conditions that impact treatment of the conditions listed above (e.g., co-morbidities or not yet allowed conditions).

## Clinical findings: You can reference office notes in lieu of writing clinical findings below. (Updates Yes ☐ No ☐)

**5** The injured worker is progressing: ☐ As expected ☐ Better than expected ☐ Slower than expected

Provide your clinical and objective findings supporting your medical opinion outlined on this form. List barriers to return to work and reason, for the injured worker's delay in recovery.

## Maximum medical improvement (MMI) (Updates Yes ☐ No ☐)

**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. 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).

Note: An injured worker may need supportive treatment to maintain his or her level of function after reaching MMI. Thus, periodic medical treatment may still be requested and provided.

## Vocational rehabilitation (Updates Yes ☐ No ☐)

**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 information on this form 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 be punished, under appropriate criminal provisions, by a fine or imprisonment or both.

| Treating physician's name (please print legibly) | | Address, city, state, nine-digit ZIP code | |
|---|---|---|---|
| Treating physician's signature | | | |
| BWC provider (Peach) number | Date | Telephone number | Fax number |