In an emergency, immediately notify your employer and seek treatment at the nearest medical facility. A BWC-certified healthcare provider must provide medical services after the initial treatment. Call MinuteMen OhioComp if you need help locating a BWC-certified medical provider.

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 MinuteMen OhioComp 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 MinuteMen OhioComp at 1-888-644-7339.
3. Report the injury by phone to MinuteMen OhioComp at 1-888-644-6266 or 216-426-0646.

MINUTEMEN OHIOCOMP MANAGED CARE ORGANIZATION

INJURED WORKER IDENTIFICATION CARD

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

MINUTEMEN OHIOCOMP MANAGED CARE ORGANIZATION

WORKERS' COMPENSATION IDENTIFICATION CARD

Employer Name: COUNTY OF SUMMIT

Employer Risk/Policy No: 37700001000

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

MEDICAL PROVIDER:

- **Please Notify MinuteMen OhioComp For Pre-Authorization**
- **All Care Is To Be Based On Ohio Workers' Compensation Treatment Guidelines**
- **Treatment Should Be Rendered By An Ohio BWC - Certified / Enrolled Provider**

Remit Bills To: 3740 Carnegie Ave., Ste. B200 • Cleveland, Ohio 44115

Claim Approval is Not Guaranteed

For Prescription-related matters, call 1-800-644-6292
www.bwc.ohio.gov

ILENE SHAPIRO
COUNTY EXECUTIVE

MINUTEMEN OHIOCOMP
MANAGED CARE ORGANIZATION

Attention: All Employees

What to do if you are injured on the job?

1. **INJURED WORKERS: Immediately report the work-related injury or illness to your Supervisor.**
2. **The work-related injury/illness is to be called within the work shift of the incident.** It is the responsibility of the employee and/or supervisor to see that this is done. You can call this number 24 hours a day and leave the required information on voice mail. The information required is as follows:

- Name of Injured Worker
- Date of Incident
- Name of Supervisor
- Work Phone Number
- Time of Incident
- Supervisor's Phone Number
- Department/Agency
- Name of Medical Provider

3. **Submit work-related injury/illness report within 48 hours of incident to your agency/department workers compensation representative. Find your representative on the Workers Comp page under the Division of Employee Benefits website, hreb.summitoh.net.**
4. **If you received medical attention inform the medical provider that you are receiving treatment for a work-related incident and that your MCO (managed care organization) is MinuteMen OhioComp.**
5. **If your work-related injury/illness requires you to be off work for an extended period of time, please notify your Supervisor/Manager of your status.**

Preferred Workplace Injury Medical Providers

HOSPITALS

Akron City Hospital
525 East Market Street, Akron, Ohio 44309
(330) 375-3000

Western Reserve Hospital
1900 23rd Street, Cuyahoga Falls, OH 44223
(330) 971-7000

Akron General Medical Center
400 Wabash Avenue, Akron, OH 44307
(330) 344-6000

OCCUPATIONAL HEALTH

Concentra Urgent Care
1450 Firestone Parkway, Akron, OH 44301

Western Reserve Occupational Health
3913 Darrow Road, Suite 100, Stow, OH 44224
(330) 688-7900

Center for Corporate Health
1860 State Road, Suite C, Cuyahoga Falls, OH 44223

Crystal Clinic Quick Care
3975 Embassy Parkway, Suite 003, Akron, OH 44333
(330) 670-4242

Any questions you may have regarding workers' compensation benefits can be directed to Traci Badock at (330) 926-2496 of the County of Summit Division of Employee Benefits.

For questions regarding medical services, please contact your MCO, MinuteMen OhioComp at 1-888-644-6266

Ohio | 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:** www.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
SUMMIT COUNTY - DD BOARD	1180 S MAIN ST STE 311	AKRON	OH	44301-1255

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
SUMMIT COUNTY				

Employer policy number	Federal ID number	Injured worker is (Check box, if applicable.) ☐ Owner/Sole proprietor ☐ Partner ☐ Individual incorporated as a corporation
37700001		

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

County of Summit · The High Point of Ohio
ILENE SHAPIRO
COUNTY EXECUTIVE

HRD - DIVISION OF EMPLOYEE BENEFITS,
WORKERS COMPENSATION
1180 S. Main St., Suite 378
AKRON, OHIO 44301
Phone:(330)926-2496 ◆ Fax:(330)643-8625

INJURY/ILLNESS REPORT

FORWARD ORIGINAL OF THIS REPORT TO YOUR AGENCY/DEPARTMENT WORKERS COMPENSATION REPRESENTATIVE

PART I: EMPLOYEE'S STATEMENT (PLEASE PRINT, USE BLACK OR BLUE INK ONLY)

NAME _____ ADDRESS HOME _____
CITY _____ ZIP CODE _____ PHONE # (HOME) _____ PHONE # (WORK) _____
SS# _____ DATE OF BIRTH _____ AGE _____ MALE/FEMALE _____
AGENCY/DEPARTMENT EMPLOYED BY _____
JOB TITLE _____ COMPLETE ADDRESS OF WHERE YOU REGULARLY REPORT TO WORK _____

DATE OF INJURY/ILLNESS _____ TIME OF INJURY/ILLNESS _____ AM/PM
DID THE INCIDENT OCCUR: BEFORE, DURING OR AFTER YOUR WORK SHIFT? _____
DID THE INCIDENT OCCUR WHILE AT WORK ON A NORMAL SHIFT OR WHILE ON OVERTIME? _____
DID THE INCIDENT OCCUR WHILE ACTUALLY ENGAGED IN WORK FOR THE COUNTY, WHILE COMING TO WORK, ON BREAK OR LEAVING WORK? _____
COMPLETE ADDRESS OF LOCATION OF INJURY/ILLNESS _____
_____
WAS THIS LOCATION ON THE EMPLOYER'S PREMISES? ☐ YES ☐ NO
DESCRIBE INJURY/ILLNESS (PART OF BODY EFFECTED AND NATURE OF INJURY OR ILLNESS) _____
_____
_____
_____
IDENTIFY THE DUTIES PERFORMED WHEN THE ACCIDENT OR EXPOSURE OCCURRED _____
_____
_____
DESCRIBE IN DETAIL THE EVENTS WHICH RESULTED IN THE INJURY OR ILLNESS (FOR AN INJURY: WHAT WERE YOU DOING? HOW DID IT HAPPEN? INCLUDE SPECIFIC OBJECTS, SUBSTANCES AND/OR MACHINES INVOLVED. IF YOU WERE LIFTING AN OBJECT, GIVE APPROXIMATE SIZE, WEIGHT AND DISTANCE LIFTED. FOR AN ILLNESS: DESCRIBE THE SUBSTANCE AND DETAILS OF HOW YOU WERE EXPOSED TO THE SUBSTANCE AND TYPE OF WORK YOU WERE DOING.)
_____
_____
_____
_____
WAS THERE ANY PROPERTY DAMAGE? ☐ YES ☐ NO IF YES, WHAT PROPERTY WAS DAMAGED? _____
_____
_____
WERE THERE INJURIES TO OTHER EMPLOYEES OR THE PUBLIC? ☐ YES ☐ NO IF YES, WHO WAS INJURED?
(INCLUDE PHONE # WHERE INJURED PARTY CAN BE REACHED) _____
DID YOU RECEIVE MEDICAL TREATMENT? ☐ YES ☐ NO IF YES, DESCRIBE _____
_____
NAME, COMPLETE ADDRESS AND PHONE # OF DOCTOR, HOSPITAL OR OTHER FACILITY PROVIDING SERVICE _____
_____
_____
NAME OF WITNESS(ES), COMPLETE ADDRESS AND PHONE # _____
_____
_____
WITNESS(ES) STATEMENTS ATTACHED? ☐ YES ☐ NO WHEN DID YOU REPORT THE INJURY/ILLNESS?
_____/_____/_____ TO WHOM DID YOU REPORT THE INJURY/ILLNESS? _____
DATE OF THIS REPORT _____/_____/_____ SIGNATURE OF EMPLOYEE _____

* IF YOU RECEIVE MEDICAL TREATMENT FOR YOUR INJURY/ILLNESS, PLEASE SUBMIT YOUR MEDICAL DOCUMENTATION TO YOUR SUPERVISOR WHEN YOU RETURN TO WORK.

PART II: SUPERVISOR'S REPORT

INJURED WORKER'S NAME _____

NATURE OF INJURY/ILLNESS (STATE EMPLOYEE'S COMPLAINTS) _____

_____

_____

REMARKS/OBSERVATIONS _____

_____

_____

DID EMPLOYEE DIE? ☐ YES ☐ NO DID EMPLOYEE REPORT BACK TO WORK? ☐ YES ☐ NO

IF YES, EMPLOYEE'S RETURN TO WORK DATE _____/_____/_____ IF THE EMPLOYEE HAS NOT RETURNED TO WORK, WHAT IS THE ESTIMATED RETURN TO WORK DATE? _____/_____/_____

DATE INJURY/ILLNESS WAS REPORTED TO YOU? _____ TIME INJURY/ILLNESS WAS REPORTED TO YOU? _____ AM/PM

DID THE INJURED WORKER PROVIDE A MEDICAL RELEASE UPON RETURNING TO WORK? ☐ YES ☐ NO

PLEASE ATTACH THE MEDICAL RELEASE TO THE INJURY/ILLNESS REPORT FORM. (AN EMPLOYEE IS NOT PERMITTED TO RETURN TO WORK UNLESS THEY SUBMIT A MEDICAL RELEASE FROM THEIR MEDICAL PROVIDER)

DID THE MEDICAL RELEASE INCLUDE RESTRICTIONS? ☐ YES ☐ NO

IF THE MEDICAL RELEASE INCLUDES RESTRICTIONS, DO THE RESTRICTIONS KEEP THE INJURED WORKER FROM PERFORMING HIS/HER ORIGINAL JOB FUNCTIONS? (JOBS FUNCTIONS PERFORMED AT LEAST (1) ONE TIME PER WEEK) ☐ YES ☐ NO

CAN THE EMPLOYER ACCOMMODATE THE INJURED WORKER RESTRICTIONS? ☐ YES ☐ NO

THE INJURED WORKER IS CLASSIFIED AS A (CHECK ONLY ONE)

☐ FULL-TIME ☐ INTERMITTENT ☐ PART-TIME ☐ RELIEF WORK ☐ OTHER

WHAT ACTIONS, EVENTS OR CONDITIONS CONTRIBUTED MOST DIRECTLY TO THIS ACCIDENT? _____

_____

_____

PRIOR TO THIS ACCIDENT, WERE ANY NEAR-MISSES REPORTED? ☐ YES ☐ NO IF SO DESCRIBE (INCLUDE DATES OF NEAR-MISSES)

_____

_____

DESCRIBE WHAT HAS BEEN DONE OR WILL BE DONE TO ELIMINATE OR MINIMIZE THE CAUSES LISTED ABOVE _____

_____

_____

SUPERVISOR'S NAME (PLEASE PRINT) _____

WORK NUMBER_____ E-MAIL ADDRESS _____

SUPERVISOR'S SIGNATURE _____

TITLE _____ DATE SIGNED_____/_____/_____

DEPARTMENT/DIVISION HEAD'S NAME (PLEASE PRINT) _____

WORK NUMBER_____ E-MAIL ADDRESS _____

DEPARTMENT/DIVISION HEAD'S SIGNATURE _____

TITLE _____ DATE SIGNED_____/_____/_____

SUPPLEMENTARY RECORD OF OCCUPATIONAL INJURIES AND ILLNESSES

THIS FORM CAN BE USED IN PLACE OF THE OSHA NO. 301P, AND IS TO BE USED TO SUPPLEMENT THE LOG AND SUMMARY OF OCCUPATIONAL INJURIES AND ILLNESSES (OSHA NO. 300P). EACH ESTABLISHMENT MUST MAINTAIN A RECORD OF EACH RECORDABLE OCCUPATIONAL INJURY OR ILLNESS. THIS REPORT MUST ALSO BE AVAILABLE IN THE ESTABLISHMENT WITHOUT DELAY AND AT A REASONABLE TIME FOR EXAMINATION BY A REPRESENTATIVE OF THE DEPARTMENT OF LABOR AND THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND STATES ACCORDED JURISDICTION UNDER THE ACT. OSHA RECORDS MUST BE MAINTAINED FOR A PERIOD OF NOT LESS THAN FIVE YEARS FOLLOWING THE END OF THE CALENDAR YEAR TO WHICH THEY RELATE.

TO BE COMPLETED BY THE WORKERS' COMPENSATION PERSONNEL [OSHA NO. _____]

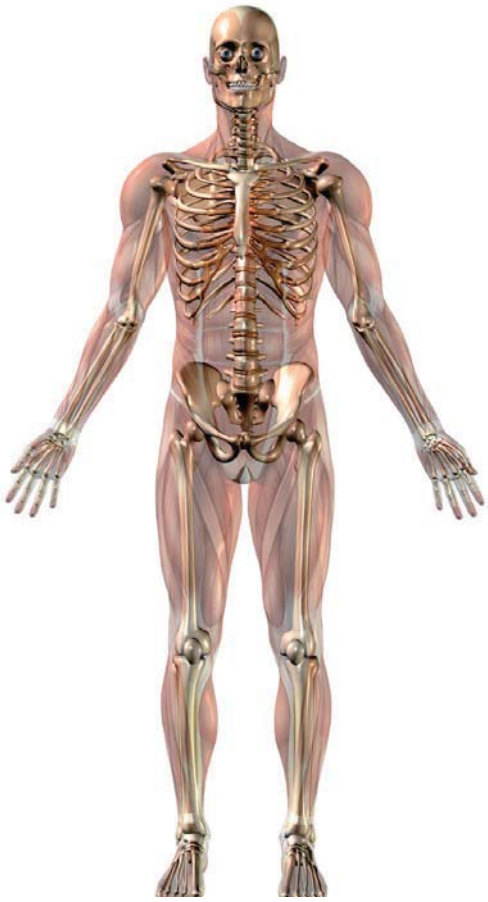
ANATOMY FORM

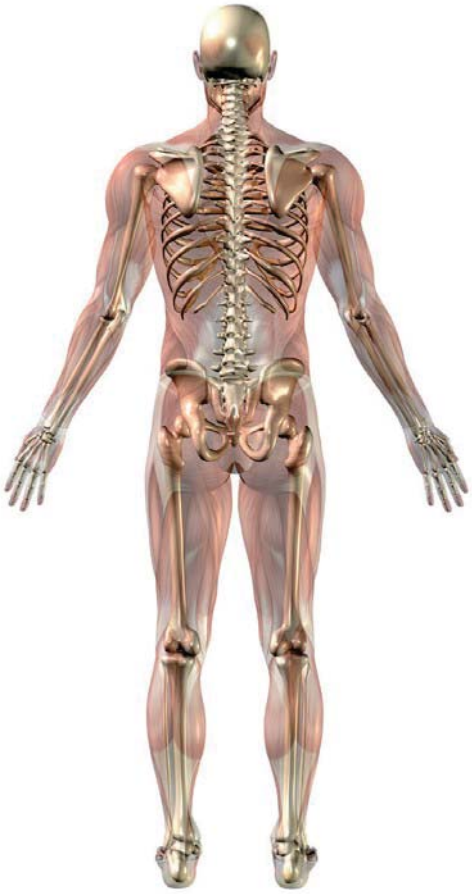
Instructions for Employee:

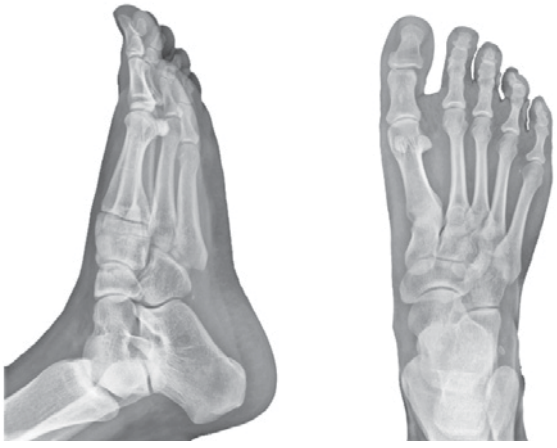
Please circle the injured body part(s) then sign and date this form.

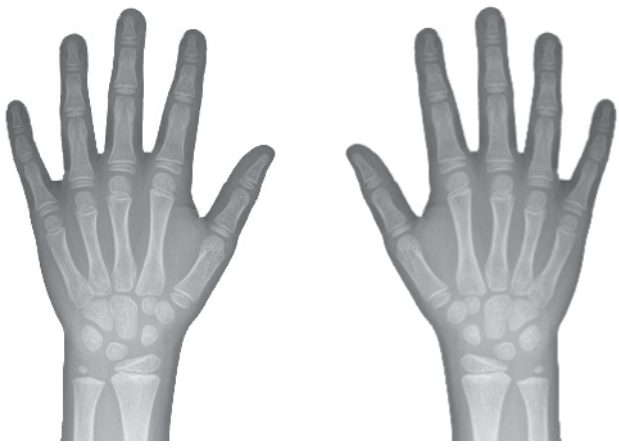
Signature of Claimant

Date









MINUTEMEN OHIOCOMP
MANAGED CARE ORGANIZATION

If you're injured at work, we're here for you!

CLAIMS REPORTING

Notify your employer immediately and complete any required accident report.

Please report your injury to MinuteMen OhioComp within 24 hours.

Report an injury by phone:
1-888-644-6266 or
216-426-0646

Fax First Report of Injury to:
1-888-644-7339 or
216-426-0651

MEDICAL MANAGEMENT

Give this information to your doctor along with your MinuteMen OhioComp ID card.

Fax treatment requests (C-9) or medical reports to:
1-888-644-7339 or 216-426-0651

Mail medical information to:
MinuteMen OhioComp
3740 Carnegie Ave., Ste. B200
Cleveland, OH 44115

Medical Management questions:
Call 1-888-644-6266

MEDICAL BILL PAYMENT

MinuteMen OhioComp will pay injury related medical bills in approved claims.

Mail medical bills to:
MinuteMen OhioComp
3740 Carnegie Ave., Ste. B200
Cleveland, OH 44115

Billing questions:
Call 1-888-644-6266
ext. 1398

Prescription-related matters:
Call 1-800-644-6292

MINUTEMEN OHIOCOMP IS YOUR MCO! Visit minutemenmco.com to learn more about our services and support.