John Carroll
UNIVERSITY
The Jesuit University in Cleveland

WORKERS' COMPENSATION

FIRST REPORT OF INJURY (FROI) FORM

Use the "First Report of Injury" (FROI) form to file a workers' compensation claim with John Carroll University. JCU is self-insured and pays its own claims, so filing your FROI with the Ohio Bureau of Workers' compensation may cause delays with processing your claim.

Instructions:

1. Complete the "injured worker and injury/disease/death info." portion of the form. Failure to complete this section may delay processing of your claim.

2. If this form is completed by the injured worker at the first visit to a medical provider, the injured worker may give the FROI to the provider to complete the treatment information section. The provider or the injured worker can then submit the FROI to either:

Sedgwick Claims Mgt. Services P.O. Box 1270 Worthington, OH 43085 Attn: New Claims (P) (800) 267-4001 (F) (614) 987-1507	John Carroll University 20700 North Park Blvd. University Heights OH 4118 Attn: Human Resources (P) (216) 397-4976 (F) (216) 397-4933

3. If the injured worker does not have the FROI form with them at the time when medical services were provided, they must contact the medical provider to complete the treatment information section.

Governor Bob Taft
Administrator/CEO James Conrad

First Report of an Injury, Occupational Disease or Death

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)

Tear off this sheet and return the completed form to your employer's managed care organization (MCO) or to your local BWC customer service office.

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	Country if different from USA		Department name
Wage $ _____ 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		
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/medical release – I am applying for recognition of my claim under the Ohio Workers' Compensation Act for work-related injuries that I did not purposely inflict. I request payment for compensation and/or medical expenses as allowable. Direct payment(s) to the providers of any medical services are authorized. I understand that I am allowing any provider who attends to, treats or examines me to release all medical, psychological and/or psychiatric information that is causally or historically related to physical or mental injuries relevant to issues necessary to the administration of my workers' compensation claim to the Ohio Bureau of Workers' Compensation, the Industrial Commission of Ohio, the employer listed in this claim, that employer's managed care organization and any authorized representatives. I further authorize the Ohio Rehabilitation Services Commission to release information about my physical, mental, vocational and social conditions that is causally or historically related to physical or mental injuries relevant to issues necessary for the administration of my workers' compensation claim to the aforementioned parties.

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			
Health-care provider signature	11-digit BWC provider number	Date		

Employer info.

Employer policy number	Check if: ☐ Employer is self-insuring ☐ Injured worker is owner/partner/member of firm			
Telephone number ( )	Fax number ( )	E-mail address	Federal ID number	Manual number
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

BWC-1101 (Rev. 9/2003)
This form meets OSHA 301 requirements

FROI-1 (Combines C-1, C-2, C-3, C-6, C-50, OD-1, OD-1-22)