



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:

Cambridge Integrated Services
300 W. Wilson Bridge Road
Worthington, OH 43085
Attn: New Claims
(P) (800) 524-3902
(F) (877) 247-4555

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.

BWC

Better Workers' Compensation

Built with you in mind

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)

Last name, first name, middle initial			Social Security number		Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Date of birth		
Home mailing address			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female				Number of dependents		
City		State	9-digit ZIP code		Country if different from USA		Department name		
Wage rate \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Month <input type="checkbox"/> Week <input type="checkbox"/> Year <input type="checkbox"/> Other _____			What days of the week do you usually work? <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thur <input type="checkbox"/> Fri <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, give accident location, street address, city, state and ZIP code)									
Date of injury/disease		Time of injury _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		If fatal, give date of death		Time employee began work _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		Date last worked	
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.)			
<i>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.</i>									
Injured worker signature			Date		E-mail address		Telephone number ()		
							Work number ()		

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? <input type="checkbox"/> Yes <input type="checkbox"/> No				Is the injury causally related to the industrial incident? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Health-care provider signature				11-digit BWC provider number			Date	

Employer policy number			<input type="checkbox"/> Employer is self-insuring <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			Was employee hospitalized overnight as an inpatient? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code					
<input type="checkbox"/> Certification - The employer certifies that the facts in this application are correct and valid.		<input type="checkbox"/> Rejection - The employer rejects the validity of this claim for the reason(s) listed below:		For self-insuring employers only <input type="checkbox"/> Clarification - The employer clarifies and allows the claim for the condition(s) below: <input type="checkbox"/> Medical only <input type="checkbox"/> Lost time	
Employer signature and title				Date	
				OSHA case number	