



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 14661
Lexington KY 40512-4661
Attn: New Claims
(P) (800) 267-4001
(F) (855) 223-9836

John Carroll University
1 John Carroll Blvd.
University Hts. OH 44118
Attn: Human Resources
(P) (216) 397-1576
(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.



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.

Form section for injured worker and injury/disease/death info. Includes fields for: Last name, first name, middle initial; Social Security number; Marital status; Date of birth; Home mailing address; Sex; Number of dependents; City; State; 9-digit ZIP code; Country if different from USA; Wage rate; What days of the week do you usually work?; Regular work hours; 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?; Occupation or job title; Employer name; Mailing address; Location; Was the place of accident or exposure on employer's premises?; Date of injury/disease; Time of injury; If fatal, give date of death; Time employee began work; Date last worked; Date returned to work; Date hired; State where hired; Date employer notified; State where supervised; Description of accident; Type of injury/disease and part(s) of body affected.

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.

Treatment info.

Form section for treatment info. Includes fields for: Health-care provider name; Telephone number; Fax number; Initial treatment date; Street address; City; State; 9-digit ZIP code; Diagnosis(es); Will the incident cause the injured worker to miss eight or more days of work?; Is the injury causally related to the industrial incident?; E code; 11-digit BWC provider number; Date; Health-care provider signature.

Employer info.

Form section for employer info. Includes fields for: 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?; Was employee hospitalized overnight as an inpatient?; 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.