Employee Accident/Injury Report

Employee Information:

Name: _____

Home Address: _____

Department: _____ Job Title: _____

Accident/Injury Information:

Date of Accident/Injury: _____ Time of Accident/Injury: _____

Authorization to Release Medical Information

Instructions
‡ Please print or type.

You can obtain this form online at www.bwc.ohio.gov

‡ List the provider(s) you are authorizing to release medical records in the space indicated on this form.
‡ Please sign and date the form, and send it to the customer service office where your claim is located or to your self-insured employer.

Injured worker name (first, M.I., last)		Date of injury	Claim number
Address	City	State	Nine-digit ZIP code
Employer name	Employer MCO or QHP		

I, the above-named injured worker, understand I am allowing the Opportunities for Ohioans with Disabilities and the providers (persons or facilities) named here (Community Mercy Occupational Health & Medicine , Springfield Regional Hospital, PLEASE LIST OTHERS AS NEEDED) that attend or examine

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