Employer: KENT STATE UNIVERSITY
Risk: 10003142000

BWC website: www.bwc.ohio.gov

Workers' Compensation Managed Care

TO REPORT AN INJURY CONTACT:

Customer Service & Treatment Approval:
(440) 899-2400 or 1-800-542-9479

Fee bills should be submitted to:

Spooner Medical Administrators, Inc.
28301 Ranney Parkway
Westlake, OH 44145

Ohio | Bureau of Workers' Compensation

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.

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 code | Country if different from USA | Department name

Wage rate $ _____ 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 | State where supervised

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 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. I request payment for compensation and/or medical benefits as allowable, and authorize direct payment to my medical providers. I permit and authorize any provider who attends, treats or examines me, the Ohio State Board of Pharmacy, the Ohio Department of Job and Family Services and the Ohio Rehabilitation Services Commission to release medical, psychological, psychiatric, pharmaceutical, vocational and social information. I understand this may include personally identifying information that is casually or historically related to my physical or mental injuries relevant to issues necessary for the administration of my claim to BWC, the Industrial Commission of Ohio, the employer in this claim, the employer's managed care organization and any authorized representatives. My previous or future BWC claims may affect decisions made in this claim. Proper administration of the present claim may require BWC to share claims information with the employers of record (or their authorized representatives) and/or my authorized representative for any and all such previous or future claims. The released claims information may include any record maintained in my claim files.

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

E code | 11-digit BWC provider number | Date

Health-care provider signature

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

Ohio | Bureau of Workers' Compensation

Physician's Report of Work Ability

Injured worker name			Claim number
Date of injury	Date of last appointment/examination	Date of this appointment/examination	Date of next appointment/examination

MEDCO-14 submission (Select one of the options below.)

1

☐ I have never completed a MEDCO-14. ***Proceed to section 2.***
☐ I have previously completed a MEDCO-14, and all of the information remains the same. ***Proceed to and complete section 8.***
☐ I have previously completed a MEDCO-14, and I am providing updates appropriately checking Yes or No on each section.

Employment/Occupation (Complete this section and proceed to section 3.) (Updates Yes ☐ No ☐)

2

Have you reviewed the description of the injured worker's job held on the date of injury (former position of employment)? Yes ☐ No ☐
If yes - please indicate who (select all sources) provided the job description ☐ Injured worker ☐ Employer ☐ MCO ☐ BWC

Work status/Injured worker's capabilities (Updates Yes ☐ No ☐)

3A

Does the injured worker have any physical or health restrictions related to allowed conditions in the claim? Yes ☐ No ☐
If yes, are the restrictions: ☐ Permanent ☐ Temporary ***Proceed to section 3B.***
If no, please check the box to indicate the injured worker is released to work as of the date of this exam. ☐ ***Proceed to section 8.***

3B

If there are restrictions, can the injured worker return to the full duties of his/her job held on the date of injury (former position of employment)? Yes ☐ No ☐
If yes, please check the box to indicate that the injured worker is released to work as of the date of this exam. ☐ ***Proceed to section 8.***
If no, please indicate when the injured worker could not do the job held on the date of injury for this period of restricted duty.
Date:_____/_____/_____.

Please estimate when the injured worker should be able to return to the job held on the date of injury for this period of restricted duty.
Date:_____/_____/_____. **Proceed to section 3C.**

3C

Please indicate which of the activities listed below the injured worker can perform (even if the response to 3B is No.)
If the injured worker is not released to the former position of employment but may return to available and appropriate work with restrictions, please indicate the possible return to work date: ____/_____/_____.
The injured worker can perform simple grasping with: ☐ Left hand ☐ Right hand ☐ Both
The injured worker can perform repetitive wrist motion with: ☐ Left hand ☐ Right hand ☐ Both
The injured worker's dominant hand is: ☐ Left ☐ Right
The injured worker can perform repetitive actions to operate foot controls or motor vehicles with: ☐ Left foot ☐ Right foot ☐ Both
If the injured worker is taking prescribed medications for the allowed conditions in this claim, can the injured worker safely:
*Operate heavy machinery: ☐ Yes ☐ No *Drive: ☐ Yes ☐ No **Perform other critical job tasks as defined by any source listed above in section 2:* ☐ Yes ☐ No

Please indicate the following: N = Never, O = Occasionally, F = Frequently, C = Continuously										Lifting/carrying	N	O	F	C	Pushing/pulling	N	O	F	C
Activity	N	O	F	C	Activity	N	O	F	C	0 - 10 lbs.					0 to 25 lbs.				
Bend					Reach above shoulder					11 - 20 lbs.					26 to 40 lbs.				
Squat/kneel					Type/keyboard					21 - 40 lbs.					41 to 60 lbs.				
Twist/turn					Work with cold substances					41 - 60 lbs.					61 to 100 lbs.				
Climb					Work with hot substances					61 - 100 lbs.					100 + lbs.				

How many total hours can the injured worker work: _____ per week _____ per day?
In an eight-hour workday, how many total hours can the injured worker: Sit: ____ hours ☐ Continuously ☐ With break
Walk: ____ hours ☐ Continuously ☐ With break Stand: ____ hours ☐ Continuously ☐ With break
Does the injured worker have any functional restrictions based only on allowed psychological conditions? ☐ Yes ☐ No If Yes, please describe in space provided below. Note: If Yes is indicated please reference the MEDCO-16 as needed.
Additionally, in this space, please provide any additional information addressing the injured worker's capabilities and/or job accommodations which may not be addressed above. _____

Proceed to section 4.

Injured worker name	Claim number	Date of injury

Disability information **(If 3B above is "NO" or dates updated - all 4A fields, including site/location if applicable must be completed)** (Updates Yes ☐ No ☐)

4A

Complete the chart below and furnish the narrative description of the diagnosis(es), site/location, if applicable, and International of Diseases (ICD) code(s) for the condition(s) being treated due to the work-related injury/disease. Please indicate if the condition is preventing the injured worker from returning to job duties he/she held on the date of injury.

Narrative description of the work-related allowed condition	Site/location if applicable	ICD code	Is the condition preventing full duty release to the job injured worker held on the date of injury?
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐

4B List all other relevant conditions that impact treatment of the conditions listed above (e.g., co-morbidities or not yet allowed conditions).

Y . (Updates Yes ☐ No ☐)

5 The injured worker is progressing: ☐ As expected ☐ Better than expected ☐ Slower than expected
Provide your clinical and objective supporting your medical opinion outlined on this form. List barriers to return to work and reason, for the injured worker's delay in recovery.

Maximum medical improvement (MMI) (Updates Yes ☐ No ☐)

6 MMI is a treatment plateau (static or well-stabilized) at which no fundamental functional or physiological change can be expected within reasonable medical probability, in spite of continuing medical or rehabilitative procedures. Has the work-related injury(s) or occupational disease reached MMI based on the above? Yes ☐ No ☐
If yes, give MMI date: _____/_____/_____. If no, please provide the proposed treatment plan, including estimated duration of each treatment (attach additional sheet if necessary).

Note: An injured worker may need supportive treatment to maintain his or her level of function after reaching MMI. Thus, periodic medical treatment may still be requested and provided.

Vocational rehabilitation (Updates Yes ☐ No ☐)

7 Vocational rehabilitation is an individualized and voluntary program for an eligible injured worker who needs assistance in safely returning to work or in retaining employment. This program can be tailored around an injured worker's restrictions and may provide job seeking skills or necessary retraining. Is the injured worker a candidate for vocational rehabilitation services focusing on return to work?
Yes ☐ No ☐ If no, please explain why and provide your recommendations to help the injured worker return to employment.

Treating physician signature - mandatory

8 I certify the information on this form is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain payment as provided by BWC, or who knowingly accepts payment to which that person is not entitled, is subject to felony criminal prosecution and may be punished, under appropriate criminal provisions, by a or imprisonment or both.

Treating physician's name (please print legibly)		Address, city, state, nine-digit ZIP code	
Treating physician's signature			
BWC provider (Peach) number	Date	Telephone number	Fax number

SMAInsideInfo

Your Information Source for Workers' Compensation

SPOONER MAI
Spooner Medical Administrators, Inc.

I just got injured at work, What do I need to know?

- **Spooner Medical Administrators, Inc. is the company that your employer selected to help with their workers' compensation claims.**
  - We will call you first to answer any questions you have and also call your employer to let them know how you are doing.
- **The Ohio Bureau of Workers' Compensation is in charge of approving your claim and will send you a letter with their decision about your claim.**
- **You will receive a letter with a medical card from the BWC that can be used for work-related injuries.**
  - If you need to see a doctor because of your injury, then you should show the doctor the card for their file.
- **The doctor that treats you must be certified by the Ohio Bureau of Workers' Compensation.**
  - If needed, we can assist you with finding a doctor.
- **The doctor must get our approval for more treatment after the initial visit.**
- **You are not required to pay the doctor for approved treatment for your allowed workers' compensation claim.**
  - If you receive a bill, call our office.
  - If you have paid for medical services out of your own pocket, then you can apply for reimbursement by sending the bill and proof of payment to our office. Please note that online purchases (i.e. Amazon) do not qualify for reimbursement and not all purchases will qualify. Call your case manager before making any purchases.
- **The Bureau of Workers' Compensation is in charge of paying for your medication for your work injury.**
- **The Bureau of Workers' Compensation is in charge of calculating payment for lost work time that meets their guidelines.**

Spooner Medical Administrators, Inc. services include case management, prior authorization of medical treatment and payment of medical bills. Contact us with any question you have about your claim or the workers' compensation process.

Spooner Medical Administrators, Incorporated
Phone (440)899-2400 or (800)542-9479
Fax (440)899-2411 or (800)542-9480
www.spoonermai.com

Fee bills should be submitted to:
28301 Ranney Parkway
Westlake, Oh 44145

EMPLOYEE'S REPORT OF INJURY

(To be completed and signed by the employee)

SAFETY STATION

_____

Company name _____ Division _____ Clock No. _____

Name (print) _____ Date of birth _____

Address _____ City _____ State _____ Zip _____

Phone number (_____) _____ SS# _____

Job title _____ Department _____ Date of hire _____

Date of Injury _____ Time: A.M. P.M. _____ Date injury reported _____

To whom did you report the injury? _____

Where were you when the injury occurred? _____

Witness(es): _____

What activity were you performing when the injury occurred? _____

(example: lifting, pushing, etc.) _____

Describe how the injury happened: _____

_____

_____

_____

_____

_____

_____

_____

Type of injury and what body part was injured? _____

(On the back of this form draw a circle around the exact part of the body which was injured)

Give name and address of treating physician/hospital: _____

_____

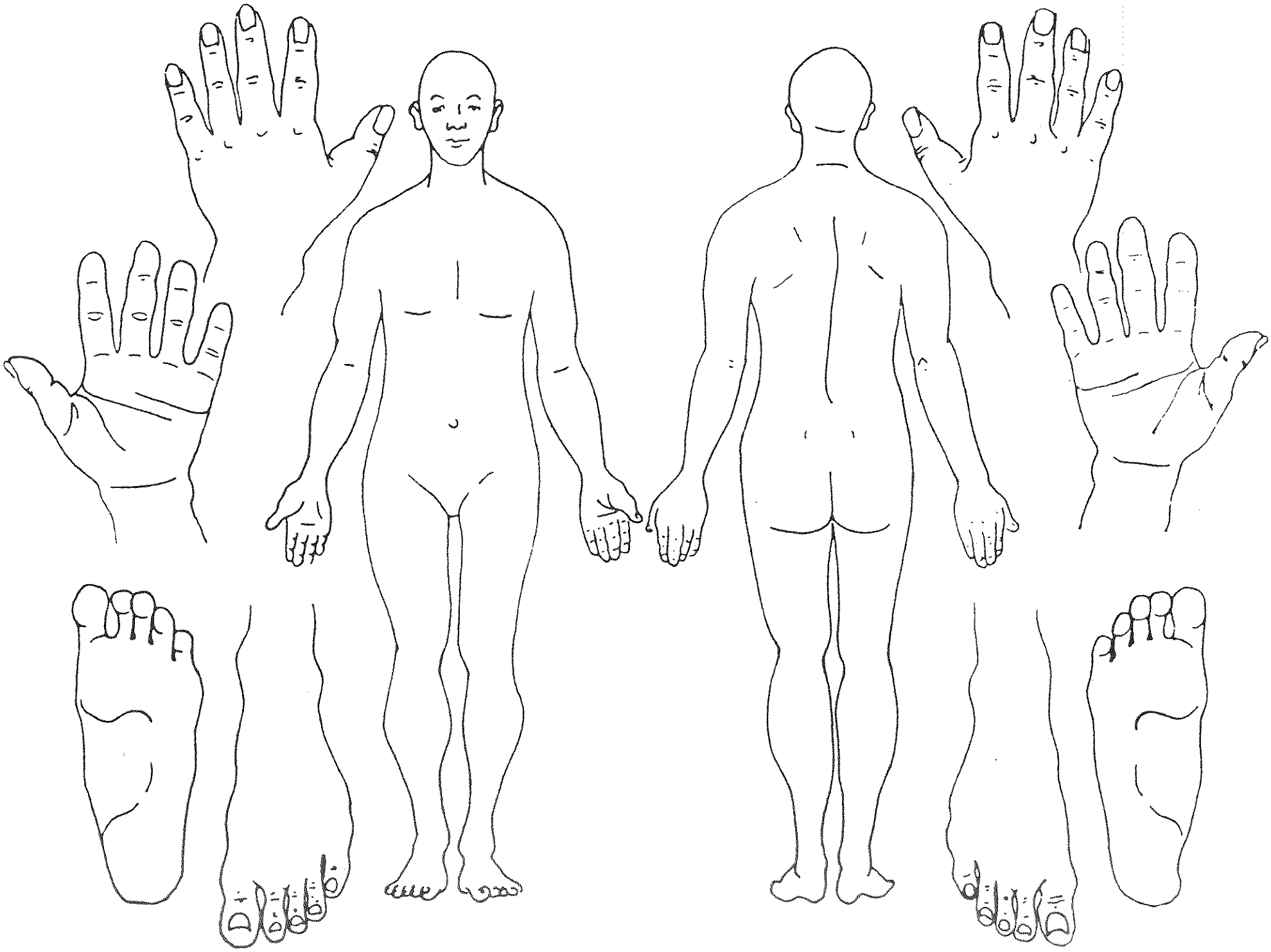
Have you had prior claims or treatment related to the same body part (s)? Yes _____ No _____

This is my description of the accident. As provided by Section 4123.651 (c) of the Ohio Revised Code, I hereby permit the release of medical information, records and reports, relative to the issues necessary for the administration of my Workers' Compensation claim to the Industrial Commission of Ohio, the Ohio Bureau of Workers' Compensation, the employer and its authorized representative, Spooner, Inc., as such medical information, records and reports may possibly pertain to a condition either allowed or alleged in my claim, or to consider payment or to determine the eligibility of payment of compensation and medical benefits under my Workers' Compensation claim. A copy shall be as good as the original.

_____ _____

Employee's Signature Date form completed

EMPLOYEE SHOULD DRAW CIRCLE AROUND INJURED PART OF BODY



LEFT FRONT BACK RIGHT