CENTER DIRECTOR'S CHECKLIST FOR NEWLY REPORTED WORK-RELATED INJURY

IF AN EMERGENCY, ALWAYS OBTAIN MEDICAL TREATMENT FIRST CALL 911

EMPLOYEE NAME: _____

DATE: _____

CENTER LOCATION: _____

Please collect the following documents and scan to Jasminn Dominguez, Human Resource Generalist at jdominguez@cleverbeeacademy.com. You can also contact her at 614-927-1765.

Be sure to ✔ of the list below to make sure you have collected everything.

Have the injured worker complete the following forms:

- ○ FROI (first report of Injury). This application must be completed in full and signed by the injured worker.
- ○ Authorization to Release Medical Information (C-101)
- ○ Accident Statement

- ○ **Provide Injured Worker** with the MEDCO-14 form to take to their medical provider and explain this form must be completed and returned to the MCO (card attached) with copy to Brightside Academy Ohio LLC, Attn: Tara Hereford. Provide them with the enclosed Concentra locations that employee must go to be examined/drug tested. They must go immediately.
- ○ **Academy Director completes** the Accident Report. If you feel the claim is questionable, please be sure on question #7 to explain the factual reason for questioning the claim in detail. Please be specific and whenever possible, secure witness statements that support your position.
- ○ **Send Human Resources** the FROI, Injured Workers Accident Statement, Authorization to Release Medical Information, Academy Director's Accident report, Witness Statement if applicable
- ○ **Please refer to the Company Handbook** regarding policy procedures and instructions on work related injuries or contact Human Resources.

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

INJURED WORKER ACCIDENT STATEMENT

Employer **CLEVER BEE ACADEMY** **Policy # 1421410-0**

Employee NAME _____ Date if Hire _____

Employee Home Address _____

_____

Telephone # ( )_____-_____

Social Security # _____ Date of Birth _____

Accident / Injury Date _____ Time of Day _____

Job Title _____

Did you report injury? YES NO To whom was it reported _____

Address where injury occurred _____

_____

Local Supervisor to whom you report _____

Were there any witnesses? If so, please list _____

_____

_____

Was Employee doing regular job when injury occurred YES NO

Please describe what happened at time of incident _____

_____

_____

Describe Injury / Illness (Part of Body, including Left or Right and Type of Injury)

_____

_____

_____

_____

What did you do after the incident? _____

_____

Did you seek medical attention YES NO

If yes, when and where _____

_____

_____

Can this incident be avoided in the future? YES NO

If yes, how? _____

_____

_____

_____

Signature: _____

Date: _____

Ohio | Bureau of Workers' Compensation

Authorization to Release Medical Information

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

Instructions

- Please print or type.
- 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 (_____) that attend or examine me to release the following medical, psychological and/or psychiatric information (excluding psychotherapy notes) that are related causally or historically to physical or mental injuries relevant to my workers' compensation claim:

- Pathology slides and immunohistochemical staining results, if applicable;
- Hospital admission history and physical; emergency room reports; hospital discharge summaries; physician office notes; physical therapist, occupational therapist or athletic trainer assessments and progress notes; consultation reports; lab results; medical reports; surgical reports; diagnostic reports; procedure reports; nursing home and skilled nursing facilities documentation; home nursing progress notes; or other listed below.

_____.

I understand I am authorizing the release of this information to the following: the Ohio Bureau of Workers' Compensation (BWC), the Industrial Commission of Ohio, the above-named employer, the employer's managed care organization or qualified health plan and any authorized representatives.

I understand this information is being released to the above-referenced persons and/or entities for use in administering my workers' compensation claim.

This authorization to release medical, psychological and/or psychiatric information shall remain in effect for as long as my workers' compensation claim remains open under Ohio law. I understand I have the right to revoke this authorization at any time. However, I must submit my revocation in writing and file it with BWC or my self-insured employer. My decision to revoke this authorization will be effective, except in the case that any provider referenced above already has relied on my authorization and released information.

I understand the provider(s) referenced above may not make my completing and signing this authorization a condition of my treatment.

I understand the parties I am authorizing the release of information to are exempted from the federal privacy requirements of the Health Insurance Portability and Accountability Act of 1996 as they administer workers' compensation programs. Information disclosed pursuant to this authorization may be redisclosed by them and may no longer be protected by the federal privacy requirements. I understand such redisclosures may include but are not limited to the following:

- A copy of the medical information the employer receives may be forwarded to BWC by the employer;
- A copy of the medical information will be available to me or my physician of record upon request to BWC or to the employer.

Injured worker (or guardian or personal representative) signature	Date

If signed by the injured worker's guardian or personal representative, provide a description of the guardian or personal representative's authority to sign on behalf of the injured worker. _____

_____.

ACADEMY DIRECTOR'S ACCIDENT REPORT

This form should be completed in its entirety by the employee's Academy Director and should accompany all employer's first report of injury or illness forms.

Policy # 1421410-0

Employee NAME: _____

Social Security # _____

1.) Date of Injury / Illness _____ Time of Day _____

Start of Shift _____

2.) Date of Hire _____

3.) Who Report the Incident? _____

4.) Time Reported _____ To Whom was it reported _____

5.) Nature of injury _____

Part of body _____ Left? Right? _____

6.) What was employee doing when the incident occurred? _____

_____

_____

7.) Describe how the incident occurred _____

_____

_____

Were there any Witnesses? If so, please provide names and contact information.

_____

_____

_____

_____

8.) Could this injury have been prevented? Yes No

If yes, please explain _____

_____

_____

_____

9.) Please list any action taken to prevent such an incident from occurring again

_____

_____

_____

10.) Is the Employee alleging a Workers' Compensation Claim? Yes No

11.) Have you any reason to believe that this was not an on-the job injury/illness? Yes No

If yes, please supply as much information / details as possible _____

_____

_____

_____

_____

_____

_____

12.) Has the employee missed any time from work? YES NO

13.) Has employee returned to work? YES Date Returned: _____

No Expected Date of Return _____

Completed by _____ Date _____
(signature)

Printed Name _____

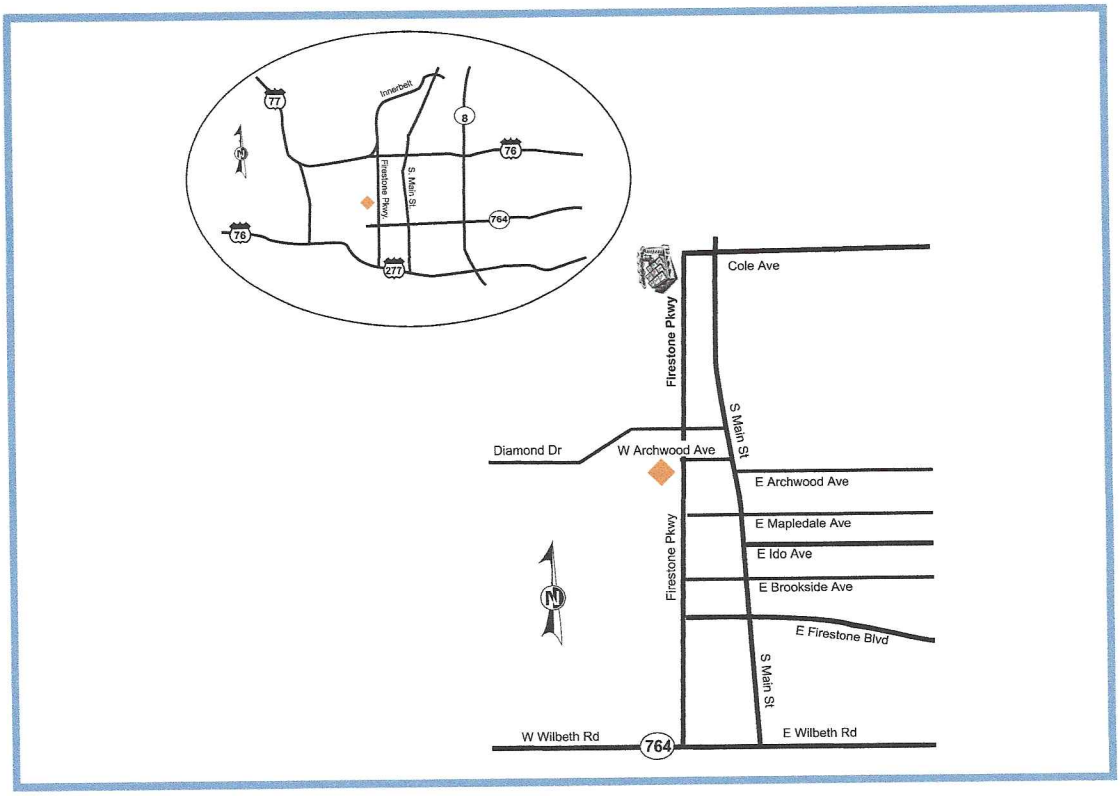
Title Academy Director

Phone # _____

PROVIDE THE EMPLOYEE WITH THE FORMS BEHIND THIS SHEET, TO TAKE WITH THEM TO THE MEDICAL CENTER

Concentra®

Downtown Akron Location



Downtown Akron
1450 Firestone Pkwy, Ste F
Akron, OH 44301
Mon-Fri: 7 am - 5 pm
Ph: 330.724.3345
Fx: 330.724.5299

- Work-related injuries receive immediate triage assessment.
- Pre-placement and DOT exam forms are provided, or you may use other DOT approved MER and/or MEC forms.
- No contract is required when working with Concentra. Our fees are competitive and adhere to the applicable state workers' compensation fee guidelines.
- Visit concentra.com/our-locations for a list of locations and driving directions.

FOR WORKERS' COMPENSATION INJURY MANAGEMENT ONLY

Brightside Academy of Ohio LLC

BWC Policy # 1421410-0

216-454-2605

Attention Provider

You are required by Rule 4123-6-02.8 to report work-related injuries within 24 hours.

Attention Employee

This card is for information purposes only. This card is not a guarantee of coverage.

Send Medical Bills to:
CareWorks
P.O. Box 182726
Columbus, Ohio 43218-2726

Customer Service: 1-888-627-7586
Injury Reporting Fax: 1-888-711-9284
Prior Authorization Fax: 1-888-627-0074
Email: CWmedical@careworks.com
Internet : www.careworksmco.com

ACCREDITED
CASE MANAGEMENT

For prescription drug information, contact 1-800-OHIOBWC or visit www.bwc.ohio.gov

Print or Fax

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 Classification 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).

Clinical findings: You can reference office notes in lieu of writing clinical findings below. (Updates Yes ☐ No ☐)

5 The injured worker is progressing: ☐ As expected ☐ Better than expected ☐ Slower than expected
Provide your clinical and objective findings 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 definition 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

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 fine or imprisonment or both.

8

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