



## 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](mailto: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.

CORPORATE HEADQUARTERS • 1111 SUPERIOR AVE. 4TH FLOORS • CLEVELAND, OH 44110

T: (216) 777-3500 • F: (216) 777-3510



## 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 <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.								
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 _____ a.m. <input type="checkbox"/> p.m.		If fatal, give date of death		Time employee began work _____ a.m. <input type="checkbox"/> p.m.		Date last worked
Date hired		State where hired		Date employer notified		State where supervised		Date returned to work
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)		
<b>Benefit application release of information</b> - 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? <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								
E code			11-digit BWC provider number			Date		
Health-care provider signature								

Employer info.

Employer policy number			<b>Check if</b> <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"/> <b>Certification</b> - The employer certifies that the facts in this application are correct and valid.			<input type="checkbox"/> <b>Rejection</b> - The employer rejects the validity of this claim for the reason(s) listed below: _____ _____			<b>For self-insuring employers only</b> <input type="checkbox"/> <b>Clarification</b> - The employer clarifies and allows the claim for the condition(s) below: <input type="checkbox"/> <b>Medical only</b> <input type="checkbox"/> <b>Lost time</b>			
Employer signature and title						Date		OSHA case number	



**CLEVER BEE**  
**ACADEMY**  
EARLY EDUCATION & CHILD CARE

## INJURED WORKER ACCIDENT STATEMENT

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

**Employee NAME** \_\_\_\_\_ Date of 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)

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What did you do after the incident? \_\_\_\_\_

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Did you seek medical attention      YES      NO

If yes, when and where \_\_\_\_\_

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Can this incident be avoided in the future?   YES   NO

If yes, how? \_\_\_\_\_

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Signature: \_\_\_\_\_

Date: \_\_\_\_\_





# Bureau of Workers' Compensation

## Authorization to Release Medical Information

### 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.

You can obtain this form online at [www.bwc.ohio.gov](http://www.bwc.ohio.gov)

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
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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.

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

If yes, please explain \_\_\_\_\_

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

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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 \_\_\_\_\_

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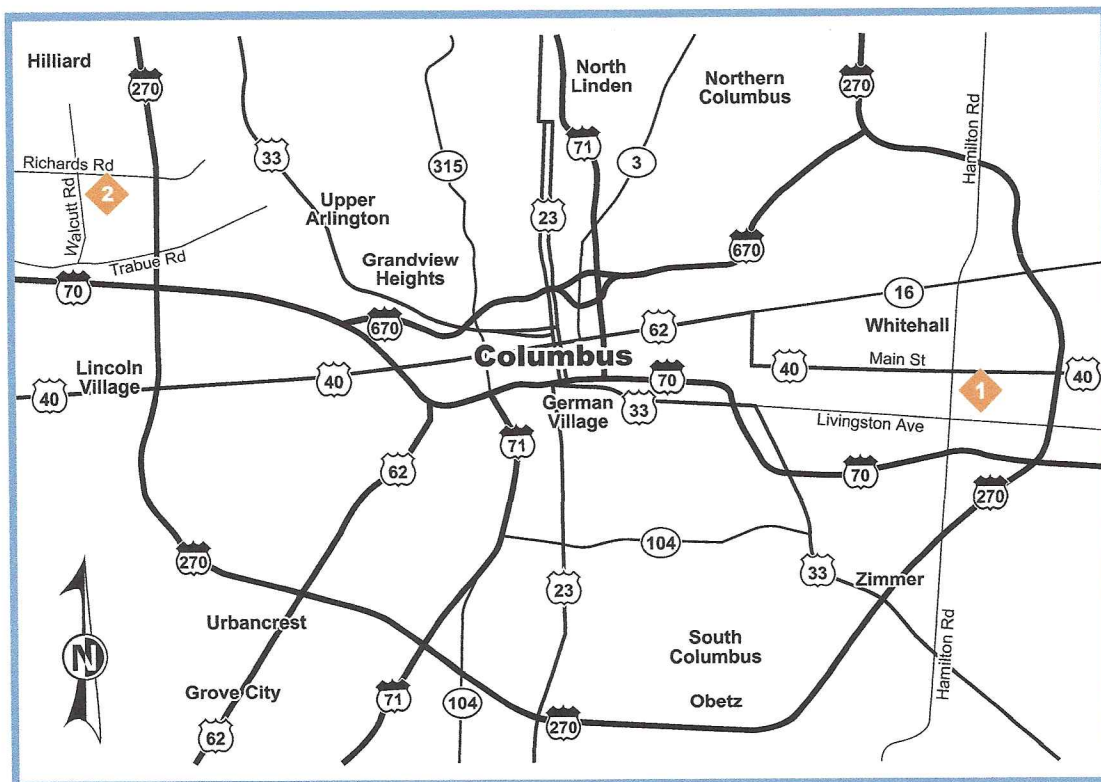




**PROVIDE THE  
EMPLOYEE WITH THE  
FORMS BEHIND THIS  
SHEET, TO TAKE WITH  
THEM TO THE  
MEDICAL CENTER**



## Columbus Locations



### 1. Columbus East

4849 E Main St  
Columbus, OH 43213  
Mon-Fri: 8 am - 5 pm  
Ph: 614.863.5188  
Fx: 614.863.3560

### 2. Columbus West

4821 Roberts Rd  
Columbus, OH 43228  
Mon-Fri: 8 am - 5 pm  
Ph: 614.850.1476  
Fx: 614.850.1478

- 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](http://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

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

Attention Provider

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](mailto:CWmedical@careworks.com)

Internet : [www.careworksco.com](http://www.careworksco.com)

ACCREDITED  
CASE MANAGEMENT

For prescription drug information, contact 1-800-CHIOBWC or visit [www.bwc.ohio.gov](http://www.bwc.ohio.gov).





# Bureau of Workers' Compensation

## Physician's Report of Work Ability

Print or Fax

Injured worker name				Claim number													
Date of injury		Date of last appointment/examination		Date of this appointment/examination		Date of next appointment/examination											
<b>MEDCO-14 submission (Select one of the options below.)</b>																	
1 <input type="checkbox"/> I have never completed a MEDCO-14. <b>Proceed to section 2.</b> <input type="checkbox"/> I have previously completed a MEDCO-14, and all of the information remains the same. <b>Proceed to and complete section 8.</b> <input type="checkbox"/> I have previously completed a MEDCO-14, and I am providing updates appropriately checking Yes or No on each section.																	
<b>Employment/Occupation (Complete this section and proceed to section 3.)</b>						(Updates Yes <input type="checkbox"/> No <input type="checkbox"/> )											
2 Have you reviewed the description of the injured worker's job held on the date of injury (former position of employment)? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes - please indicate who (select all sources) provided the job description <input type="checkbox"/> Injured worker <input type="checkbox"/> Employer <input type="checkbox"/> MCO <input type="checkbox"/> BWC																	
<b>Work status/Injured worker's capabilities</b>						(Updates Yes <input type="checkbox"/> No <input type="checkbox"/> )											
3A Does the injured worker have any physical or health restrictions related to allowed conditions in the claim? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, are the restrictions: <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary <b>Proceed to section 3B.</b> If no, please check the box to indicate the injured worker is released to work as of the date of this exam. <input type="checkbox"/> <b>Proceed to section 8.</b>																	
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 <input type="checkbox"/> No <input type="checkbox"/> If yes, please check the box to indicate that the injured worker is released to work as of the date of this exam. <input type="checkbox"/> <b>Proceed to section 8.</b> 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: _____ <b>Proceed to section 3C.</b>																	
<b>Please indicate which of the activities listed below the injured worker can perform (even if the response to 3B is No.)</b> 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: <input type="checkbox"/> Left hand <input type="checkbox"/> Right hand <input type="checkbox"/> Both The injured worker can perform repetitive wrist motion with: <input type="checkbox"/> Left hand <input type="checkbox"/> Right hand <input type="checkbox"/> Both The injured worker's dominant hand is: <input type="checkbox"/> Left <input type="checkbox"/> Right The injured worker can perform repetitive actions to operate foot controls or motor vehicles with: <input type="checkbox"/> Left foot <input type="checkbox"/> Right foot <input type="checkbox"/> Both If the injured worker is taking prescribed medications for the allowed conditions in this claim, can the injured worker safely: *Operate heavy machinery: <input type="checkbox"/> Yes <input type="checkbox"/> No *Drive: <input type="checkbox"/> Yes <input type="checkbox"/> No *Perform other critical job tasks as defined by any source listed above in section 2: <input type="checkbox"/> Yes <input type="checkbox"/> No																	
<b>Please indicate the following: N = Never, O = Occasionally, F = Frequently, C = Continuously</b>																	
Activity		N	O	F	C	Activity		N	O	F	C	Lifting/carrying		N	O	F	C
Bend		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reach above shoulder		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	0 - 10 lbs.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat/kneel		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type/keyboard		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11 - 20 lbs.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twist/turn		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work with cold substances		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21 - 40 lbs.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work with hot substances		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	41 - 60 lbs.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	61 - 100 lbs.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	100 + lbs.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3C 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 <input type="checkbox"/> Continuously <input type="checkbox"/> With break Walk: _____ hours <input type="checkbox"/> Continuously <input type="checkbox"/> With break Stand: _____ hours <input type="checkbox"/> Continuously <input type="checkbox"/> With break Does the injured worker have any functional restrictions based only on allowed psychological conditions? <input type="checkbox"/> Yes <input type="checkbox"/> 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.																	



Injured worker name		Claim number	Date of injury				
<b>Disability information</b> (If 3B above is "NO" or dates updated - all 4A fields, including site/location if applicable must be completed)			(Updates Yes <input type="checkbox"/> No <input 6"="" style="text-align: center; vertical-align: middle;" type="checkbox/&gt;)&lt;/td&gt; &lt;/tr&gt; &lt;tr&gt; &lt;td rowspan="/> <b>4A</b>	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 <input type="checkbox"/> No <input type="checkbox"/>				
			Yes <input type="checkbox"/> No <input type="checkbox"/>				
			Yes <input type="checkbox"/> No <input type="checkbox"/>				
			Yes <input type="checkbox"/> No <input type="checkbox"/>				
<b>4B</b>	List all other relevant conditions that impact treatment of the conditions listed above (e.g., co-morbidities or not yet allowed conditions).						
<b>Clinical findings: You can reference office notes in lieu of writing clinical findings below.</b>			(Updates Yes <input type="checkbox"/> No <input center;="" middle;"="" text-align:="" type="checkbox/&gt;)&lt;/td&gt; &lt;/tr&gt; &lt;tr&gt; &lt;td style=" vertical-align:=""/> <b>5</b>	The injured worker is progressing: <input type="checkbox"/> As expected <input type="checkbox"/> Better than expected <input type="checkbox"/> 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.			
<b>Maximum medical improvement (MMI)</b>			(Updates Yes <input type="checkbox"/> No <input center;="" middle;"="" text-align:="" type="checkbox/&gt;)&lt;/td&gt; &lt;/tr&gt; &lt;tr&gt; &lt;td style=" vertical-align:=""/> <b>6</b>	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 <input type="checkbox"/> No <input type="checkbox"/> 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.							
<b>Vocational rehabilitation</b>			(Updates Yes <input type="checkbox"/> No <input center;="" middle;"="" text-align:="" type="checkbox/&gt;)&lt;/td&gt; &lt;/tr&gt; &lt;tr&gt; &lt;td style=" vertical-align:=""/> <b>7</b>	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 <input type="checkbox"/> No <input type="checkbox"/> If no, please explain why and provide your recommendations to help the injured worker return to employment.			
<b>Treating physician signature - mandatory</b>							
<b>8</b>	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.						
	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			