educational service center
of Central Ohio

2080 CITYGATE DRIVE
COLUMBUS, OH 43219
614.445.3750 | www.escco.org

MEMORANDUM I Office of Business Services

The Educational Service Center of Central Ohio is a self-insured employer in regards to the Ohio Workers' Compensation Program, meaning the Ohio Bureau of Worker's Compensation (BWC) has granted the authority to the ESC to administer their own workers' compensation claims. A self-insuring employer agrees to abide by the BWC rules and regulations. Benefits are paid directly to the injured employee and service providers instead of being run through a state insurance fund.

The ESC of Central Ohio utilizes the services of Hunter Consulting Company to administer claims. Please contact Penny Lammers if you need assistance:

Penny Lammers, Hunter Consulting Company
Email: plammers@hunterconsulting.com
Phone: 1.800.486.6652, ext. 103

The ESCCO injury report must be completed within 24 hours from the time of the injury, and submitted to the Business Services office. The enclosed First Report of Injury (FROI) form must be completed by your provider and sent to Hunter Consulting.

If you sustain an injury at work, please complete the following steps:

1. Notify your supervisor **immediately**.
2. An employee injury/accident report must be completed within 24 hours and submitted to the Office of Business Services.
    a. Mail: 2080 Citygate Dr., Columbus, OH 43219
    b. Fax: 614.445.3772
3. Contact Human Resources if you will be off work for more than 3 days.
    a. Phone: 614.445.3750
    b. Email: leaveofabsence@escco.org.

You may also contact the ESC if you have additional questions and concerns regarding your claim:

Kim Kelso, ESC of Central Ohio
kimberly.kelso@escco.org
614.542.4181

educational service center
of Central Ohio

2080 CITYGATE DRIVE
COLUMBUS, OH 43219
614.445.3767 | www.escco.org

EMPLOYEE INJURY/ACCIDENT REPORT

Return to Business Services within 24 hours. All fields must be completed.
Fax: 614.445.3772

ATTENTION: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the fullest extent possible while the information is being used for occupational safety and health purposes.

This Employee Injury/Accident Report must be filled out when a recordable work-related injury or accident has occurred. This form assists the ESC of Central Ohio in understanding the extent and severity of work-related incidents. These forms must be completed, signed by the employee and appropriate supervisor and submitted to the Office of Business Services within 24 hours.

Information to be completed by the employee.

Name:_____

Address: _____

City: _____ State: _____ ZIP: _____

Date of Birth: ___/___/____ Date Hired: _____

☐ Male ☐ Female

Job Title: _____

Department Name: _____

Date of Injury/Accident: _____

Building/Location of incident: _____

Address, City, State, ZIP:

_____

Time employee began work: _____ am / pm

Time of injury/accident: _____ am / pm

Was medical attention or emergency treatment necessary?

☐ Yes ☐ No

If Yes, provide name of physician or health care provider.

_____

Where was treatment given, if off the work site?

_____

Was employee treated in an emergency room?

☐ Yes ☐ No

Was employee hospitalized overnight as an in-patient?

☐ Yes ☐ No

Was treatment prescribed?

☐ Yes ☐ No

What was employee doing immediately prior to accident? (Describe activity, as well as the tools, equipment or material being used. Be specific.)

Name a witness:

_____

What happened? How did the injury occur?

Describe the injury. Be specific, including which part of the body was affected.

Was first aid required? Explain.

Will this injury cause loss of time? ☐ Yes ☐ No

If yes, how many days? _____

Is this an aggravation of a previous injury? ☐ Yes ☐ No

Have you ever had a similar injury? ☐ Yes ☐ No

What object or substance directly harmed the employee? (If this does not apply, write "N/A")

Signatures

I certify that the above information is accurate to the best of my knowledge.

_____

Signature of Employee ***Date***

Signature is verification that the supervisor/ coordinator/principal has checked the validity and completeness of the above statement.

Supervisor/Coordinator/Principal Comments:

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

catamaran

Instant Coverage Workers' Compensation Prescription Program for Educational Services Center of Central Ohio

Employee's Name: _____

Employee's ID:
(Please use a unique #) C_____

Employer: **ESCCO**

RxGROUP: **B30921**

RxBIN: **610011**

RxPCN: **IRX**

Attention Pharmacist
Please retain for your records
Billing is through Catamaran

catamaran

Customer Service:
1-800-547-3330

Covered medications include only
those normally used in Occupational injury cases.

Process prescriptions through Catamaran

modern MEDICAL INCORPORATED

Administered By: Modern Medical, Inc.
1-800-547-3330