INJURY ON THE JOB CLAIM PROCEDURES

EMPLOYER AND BWC POLICY #		YOUR Workers' Comp. Contact:	
Name:	**Geauga County**	**Name:**	**Kathleen Hostutler**
Address:	**470 Center Street, Bldg. 4**	**Title:**	**Human Resources Specialist**
City, State, Zip:	**Chardon, OH**	**Phone:**	**440-279-1672**

BWC Policy Number: 32800001-0

IF YOU EXPERIENCE AN ON THE JOB INJURY:

- Report the injury/incident to your supervisor IMMEDIATELY
- Complete the Geauga County Employee's Incident/Accident Report and return to your supervisor immediately if possible or within 24 hours of the injury/incident. *If you were involved in a vehicle accident involving a county car, complete the Vehicle Incident/Accident Report as well.*
- If medical treatment is necessary, please use a BWC-certified medical provider (see enclosed).
- Give your MCO Identification Card and MEDCO-14 Form (in this packet) to the medical provider to ensure all bills and necessary documents are sent to the correct address.
- ***Make sure you have your completed MEDCO-14 Form when you leave your doctor/urgent care.***
- Return the Medco 14 to your Supervisor immediately as notification of your medical condition.

See enclosed insert for Medical Providers

YOUR MANAGED CARE ORGANIZATION IS:

CompManagement Health Systems, Inc.

P. O. Box 1040
Dublin, Ohio 43017
On-Line Reporting: www.chsmco.com

Fax: 1-800-334-4229
Customer Service: 1-888-247-7799
Injury Reporting: 1-888-247-4800

11/2014

Geauga County Incident/Accident Report
To be completed by Employee/Volunteer

PRINT IN BLUE INK

PLEASE RETURN YOUR COMPLETED FORM TO YOUR SUPERVISOR IMMEDIATELY IF POSSIBLE BUT NO LATER THAN 24 HOURS OF INCIDENT

Employer: GEAUGA COUNTY **Department:**_____
Job Title_____ **Policy #32800001-0**
Location of Injury/Incident: _____ **Hire Date:**_____

Name_____ Social Sec. No._____

Home Address_____ Birth Date_____ Sex: ☐ Male ☐ Female

City/State/Zip_____ Telephone: ( )_____

Date of injury **or** onset of symptoms_____ Time_____ ☐ am ☐ pm
Described what caused the injury/symptoms, what you were doing **just before** the incident, and what you did **after** the incident (if you need more space, write on the back of this form). **Be specific - name any objects or substances involved:**_____
_____
_____
_____

Did anyone see you get hurt? ☐ Yes ☐ No If yes, who?_____

Did you report this incident to anyone? ☐ Yes ☐ No If not, why not?_____

If yes, to whom did you report it?_____ Title/Position_____ When?_____

What part(s) of your body was/were affected? (BE SPECIFIC: for example, right elbow, left knee, right index finger):
_____
_____

What type of injury did you experience? (BE SPECIFIC: for example, bruise, scrape, laceration, pull)_____
_____

Was any first aid provided at the scene? ☐ Yes ☐ No If yes, describe:_____
_____

Did you seek other medical treatment? ☐ Yes ☐ No If yes, when?_____
Where?_____ If treatment was not sought immediately, explain why: _____
_____

Is this an aggravation of a previous injury/symptom? ☐ Yes ☐ No If yes, when were you last treated for the previous injury? _____ By whom or where?_____

Have you ever had a similar injury? ☐ Yes ☐ No If yes, describe other injury:_____
_____

Medical Release

Under current workers' compensation law, the employer is entitled to a signed medical release

I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to **disclose such information** to my employer, my employer's managed care organization, or to my employer's designated representative, **CompManagement, Inc.** A copy of this form will serve as the original.

Employee Name (print)_____

Employee Signature_____ Date (required)_____

11/2014

GEAUGA COUNTY
SUPERVISOR'S INVESTIGATION REPORT

Employer: Geauga County
Department:_____
Employee Name:_____ Soc. Sec. #_____
Date of Injury:_____

Was an investigation completed concerning the circumstances of this injury? ☐ Yes ☐ No

Were there any witnesses to this injury? ☐ Yes ☐ No
If yes, witness statements should be attached.

Was the injury a result of horseplay? Under the influence of drugs, or purposely self-inflicted? If yes, please specify: ☐ Yes ☐ No

_____
_____
_____

Has there been any recent disciplinary action taken against this employee? ☐ Yes ☐ No
If yes, please describe:

_____
_____

Has the employee missed any work previously due to similar industrial or non -industrial conditions? If so, when? ☐ Yes ☐ No _____

Has the employee submitted medical documentation for the injury? ☐ Yes ☐ No
If so, please attach.

If known, please provide us with the name, address and telephone number of the attending physician and/or facility:

_____
_____
_____
_____

Has the employee returned to work? ☐ Yes ☐ No
Last day worked_____ Returned to work_____

If not, what is the current estimated date of return?_____

With the information you have, would you recommend the claim be accepted? ☐ Yes ☐ No
If no, why?_____
_____

_____ _____ _____
Employer's signature Title Date

Please send completed Supervisor Investigation Report, Employee Incident/Accident Report, and any witness Statements to your Workers' Compensation Coordinator at the Commissioners' Office.

GEAUGA COUNTY
STATEMENT OF WITNESS TO ACCIDENT

Employer: Geauga County **Policy #3280001-0**

I. INCIDENT IDENTIFICATION INFORMATION

Name of employee alleging incident_____ Shift_____

Job Title_____ Department_____

II. WITNESS STATEMENT

Your name has been given as a witness to an incident alleged by the above individual. Through your cooperation, information can be obtained to complete the investigation of this incident. Therefore, it will be appreciated if you will answer each of the following questions and promptly return your completed statement.

Your name_____

Your address_____ Your telephone number ( ) _____ - _____

_____

Did you see an accident involving the above employee? ☐ Yes ☐ No

If not, how did you learn about the accident?_____

_____

If you did see an accident occur: Date of accident_____ Time of accident_____ ☐am ☐pm

Describe what you saw: _____

_____

_____

_____

_____

_____

_____

_____

_____ _____ _____

Your signature Please print your name Date

Job Title:_____Department_____

State of Ohio ¶

County of _____ ¶

Before me, a Notary Public in and for said state, personally appeared the above named who acknowledged before me that he/she did sign the foregoing instrument and that the same is his/her free act and deed.

In testimony whereof, I have hereunto affixed my name and official seal at _____, Ohio this _____ day of _____, 19_____.

(SEAL) **(signed)_____**

Name (printed or typed)_____

Notary Public, State of Ohio

My Commission Expires_____(date)