

# FINDLAY

THE UNIVERSITY OF FINDLAY

## MEMORANDUM

TO: The University of Findlay Community

FROM: Robert Link  
Business Manager, Director of Human Resources

RE: Self-Insured Workers' Compensation Policy

DATE: December 14, 2009

The University of Findlay is self-insured for work-related injuries and accidents, which requires specific procedures be followed when reporting work-related injuries. Should an employee sustain a work-related injury, he/she must complete the attached *Self-Insured Workers' Compensation Packet* immediately. Please keep in mind that timely reporting is very important.

Change in The University of Findlay's *Self-Insured Bureau of Workers' Compensation (BWC)* Plan. The BWC accepted the University's voluntary withdrawal from its Qualified Health Plan (QHP) certification, effective July 1, 2007. The University of Findlay will no longer be certified to participate in the QHP and shall revert to The University of Findlay self-administered program conducted pursuant to Chapter 4123-7 of the Ohio Administrative Code.

If you have any questions, please contact me at ext. 4528.

## Accident Reporting Procedure

This form can be obtained online at [www.findlay.edu](http://www.findlay.edu)

### INSTRUCTIONS:

- Review document.
- Sign and date form and return to the Office of Human Resources.

In an event of an accident or injury, no matter how minor, the *Injured Person's Report of Accident* must be completed and directed to the supervisor immediately and no later than the end of the shift during which the accident occurred. If the injured worker seeks treatment the following must be completed:

1. Complete the entire *Self-Insured Workers' Compensation Packet* immediately or as soon as possible after medical treatment.
2. Telephone the Office of Human Resources 419-434-4528 (ext. 4528) immediately. If after hours, notify security by telephone 419-434-4799 (ext. 4799). You must report any injuries sustained at work in order to establish valid claims under state workers' compensation law. In addition, the University must comply with federal and state injury recordkeeping requirements.
3. After a medical appointment, you are required to report directly back to your supervisor. If your shift has ended or the physician sends you home, you must contact your supervisor prior to your next scheduled shift.
4. If a medical visit is not required at the time of injury, but is later necessary, you must immediately notify your supervisor. If you are unable to contact your supervisor, notify the Office of Human Resources 419-434-4528 (ext. 4528).

### Safety Concern Reporting Procedure

Each employee is individually responsible for accident prevention. It benefits all employees and the University if you report any situation or condition which you believe may present a safety hazard. The University encourages you to report your concerns to either your immediate supervisor or the Office of Human Resources. The matter will be investigated immediately.

### Authorization to Release Medical Information

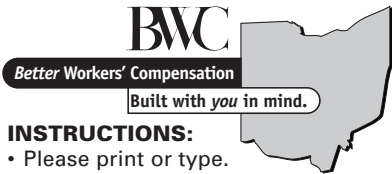
Complete the attached *Ohio Bureau of Workers' Compensation Authorization to Release Medical Information* (Form C101).

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Injured Person Signature

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Date



# Authorization to Release Medical Information

This form can be obtained online at [www.ohiobwc.com](http://www.ohiobwc.com)

**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 to the 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	9-digit ZIP code
Employer name		Employer MCO or QHP	

I, the above-named injured worker, understand I am allowing the Ohio Rehabilitation Services Commission and the following providers (persons or facilities) that attend, treat or examine me (list providers here)

\_\_\_\_\_, 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:

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

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 (IC), the above-named employer, the employer's managed care organization (MCO) or qualified health plan (QHP) 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. However, I understand I have the right to revoke this authorization at any time, but my revocation must be submitted in writing and filed 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 (HIPAA) 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 here a description of the guardian or personal representative's authority to sign on behalf of the injured worker \_\_\_\_\_

## Checklist for Handling Work-Related Injury

This form can be obtained online at [www.findlay.edu](http://www.findlay.edu)

### INSTRUCTIONS:

- Print or type.
- Sign and date form and return to the Office of Human Resources

Injured worker name (first, M.I., last)		Date and time of Injury	
Address	City	State	9-digit ZIP code
Employer name		Department	

When an accident occurs, follow the steps listed below:

1. A supervisor or a designed representative should attend to the injured worker. If the injured worker needs to seek treatment, the supervisor or a designated representative should accompany the injured worker to the locations listed below. Be sure to take a *Self-Insured Workers' Compensation Packet* with you.
  - a. Cosiano Health Center on-campus facility, if the injury is minor.
  - b. Well at Work, 3949 North Main St., Findlay, OH 45840, 419-425-5121, if the injured worker's location is the Main Campus or The All Hazards Training Center.
  - c. Emergency Room of Blanchard Valley Regional Health Center, 145 West Wallace St., Findlay, OH 45840, 419-423-5207, if the injured worker's location is the East or South Campus.
  - d. In the case of an emergency or after-hours event, employees should go to the nearest hospital emergency room or urgent care center (if appropriate) for treatment.

It is highly recommended that the employee utilize a Bureau of Workers' Compensation Certified Physician, since there are specialized documentation and forms to be completed in a timely manner.

Make sure the provider knows the injury is work related.

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

2. Report the injury to the Office of Human Resources within 24 hours. Failure to report an injury in a timely manner may affect the processing of benefit and compensation requests and may also lead to disciplinary action up to and including termination of employment.  
Date completed: \_\_\_\_\_
3. Have the provider and injured worker complete the *First Report of Injury* (FROI) if possible before leaving the place of treatment and return it to the Office of Human Resources within 24 hours along with a completed *Injured Person's Report of Accident*. Give the enclosed Provider Notice to place of treatment.  
Date completed: \_\_\_\_\_
4. Notify the Office to Human Resources with any details related to the injury, e.g., return to work date, any restrictions or reasonable accommodations, etc. Send back up paperwork given to injured worker by the provider as well as Accident Report and FROI.  
Information and date sent to HR: \_\_\_\_\_
5. Have the injured worker contact the Director of Human Resources at 419-434-4528 as soon as possible.

\_\_\_\_\_  
Injured Person Signature

\_\_\_\_\_  
Date

Accident File # (completed by HR)

## Injured Person's Report of Accident

This form can be obtained online at [www.findlay.edu](http://www.findlay.edu)

**INSTRUCTIONS:**

- Print or type.
- Sign and date form and return to the Office of Human Resources

Employer	Employer Address
Location - if different from mailing address	Date of Report

Injured Worker Name (first, M.I., last)	Age	Sex	ID #	Social Security #
Address	City	State	9-digit ZIP code	
Phone #	Occupation	Department		

Date of Accident/Illness	Time (designate a.m. or p.m.)
Place of treatment for injury/illness	Exact location of accident
Job or activity at time of accident	Were you working at the time of accident?
Supervisor at time of accident	Names of witnesses to accident
Name of person to whom injury was reported	Name and address of physician, if seen
Name and address of hospital, if hospitalized	

Report prepared by: \_\_\_\_\_ Position: \_\_\_\_\_

Description of Accident - In the space below, describe how your injury was sustained and state in detail what you were doing at the time and what you did immediately thereafter. Include details such as how the accident occurred, the specific body parts affected, what injured you: \_\_\_\_\_

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Describe any unsafe acts: \_\_\_\_\_

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Describe any unsafe conditions: \_\_\_\_\_

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\_\_\_\_\_  
Injured Person Signature

\_\_\_\_\_  
Date



Better Workers' Compensation

Built with you in mind



# First Report of an Injury, Occupational Disease or Death

### 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)

Tear off this sheet and return the completed form to your employer's managed care organization (MCO) or to your local BWC customer service office.

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.								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? <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 _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		If fatal, give date of death		Time employee began work _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		Date last worked	Date returned to work
Date hired			State where hired			Date employer notified			
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)			
<i>Benefit application/medical release – I am applying for recognition of my claim under the Ohio Workers' Compensation Act for work-related injuries that I did not purposely inflict. I request payment for compensation and/or medical expenses as allowable. Direct payment(s) to the providers of any medical services are authorized. I understand that I am allowing any provider who attends to, treats or examines me to release all medical, psychological and/or psychiatric information that is causally or historically related to physical or mental injuries relevant to issues necessary to the administration of my workers' compensation claim to the Ohio Bureau of Workers' Compensation, the Industrial Commission of Ohio, the employer listed in this claim, that employer's managed care organization and any authorized representatives. I further authorize the Ohio Rehabilitation Services Commission to release information about my physical, mental, vocational and social conditions that is causally or historically related to physical or mental injuries relevant to issues necessary for the administration of my workers' compensation claim to the aforementioned parties.</i>									
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				
Health-care provider signature				11-digit BWC provider number			Date		

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



# **PROVIDER NOTICE**

**THE UNIVERSITY OF FINDLAY IS  
SELF-INSURED FOR WORKERS'  
COMPENSATION  
EFFECTIVE: JULY 1, 2000.**

**PLEASE SEND ALL CORRESPONDENCE,  
BILLING, AND INFORMATION TO:**

**DIRECTOR OF HUMAN RESOURCES  
THE UNIVERSITY OF FINDLAY  
1000 NORTH MAIN ST.  
FINDLAY, OH 45840  
FAX 419-434-5976**

**IF YOU HAVE ANY QUESTIONS, PLEASE CALL  
419-434-4528.**

**THANK YOU.**