Employee Accident/Injury Report

Employee Information:	
Name:	
Home Address:	
Department:	Job Title:
Accident/Injury Information:	
Date of Accident/Injury:	Time of Accident/Injury:

Authorization to Release Medical Information

Instructions

‡ Please print or type.

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

‡ 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		Claimnumber
Address	City		State	Nine-digit ZIP code
Employer name	Employer MC	O 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 (Community Mercy Occupational Health & Medicine , Springfield

Regional Hospital, PLEASE LIST OTHERS AS NEEDED) that attend or examine