What to do if you experience an on the job injury or illness

If you become injured or sick on the job, we want to help you get well and get back to work. A work-related injury or illness can upset your life. You may be confused about how and where to get the attention you need to get back on your feet. To help you through this difficult time, your employer has formed a team to assist you in your recovery. The team includes:

• Your employer's workers' compensation representative - a person you can turn to for advice on how to get started.

• Hunter Consulting - known for its understanding of work-related injuries and illnesses and its rapid response to injured employees' needs.

Hunter Consulting Company
Attn: Penny Lammers
6600 Clough Pike, FL 2
Cincinnati, OH 45244
Phone (513) 372-8703
Email: plammers@hunterconsulting.com

• An experienced provider network -physicians, therapists, and other health professionals specially qualified to treat your work-related injury or illnesses.

Hunter Consulting is ready to help you, the most important member of the team, get well so you can get back to work. We will stand by you throughout the entire workers' compensation process, helping make sure you have access to the quality care you deserve. When you become sick or injured on the job, Hunter Consulting is ready to assist you in getting the care you need.

Follow these five steps to help ensure you get the treatment and benefits due you.

1. Report the Injury Immediately

Unless it is a life-threatening emergency, report your injury, accident, or illness to your supervisor or Kenyon College representative before you leave work. Failure to report an injury may cause delay in getting benefits due to you.

2. Get your Forms - Injury Reporting Kit

This packet contains your necessary forms, which include an Initial Report Form, First Report of Injury and a Medical Release. Complete the forms with your supervisor or Kenyon Representative. He or she will need these in order to report your injury.

3. Seek Medical Treatment

Your visit to the provider should take place as soon as possible after your injury. At your visit, have the treating physician complete the Physician's Report of Work Ability form and sign the First Report of Injury form. We ask that you seek medical attention from the Medical Group listed below. You may seek treatment from any provider; however, the provider must be BW certified.

(Non-Emergency)		(Emergency)	
Name:	Mid- Ohio Corporate Care	**Name:**	Knox Community Hospital
Address:	1490 Coshocton Road	**Address:**	1330 Coshocton Road
City, State, Zip:	Mt Vernon, OH 43050	**City, State, Zip:**	Mt Vernon, OH 43050
Phone:	(740) 393-9675	**Phone:**	(740) 393-9000
Hours:	M - F 7:00 am – 5:00 pm	**Hours**:	24 Hours

4. Return your Forms to your Supervisor and your Workers' Compensation Representative in Human Resources

Return all completed forms and medical documentation to your supervisor and your workers' compensation representative in Human Resources immediately.

5. Let Your Employer Know

After each appointment, let your Kenyon College representative know that you have seen your medical provider. In addition, Hunter Consulting will assist to manage your care, help arrange your return to work, and keep your employer updated on your condition.

INITIAL REPORT OF WORK-RELATED INJURY or ILLNESS

HUNTER CONSULTING

1. **Employee Name** _____ _____ 2. **Date of Birth** (mo./day/yr.)_____/_____/_____

3. **Soc. Sec. #**_____-_____-_____ 4. ○ **Female** ◉ **Male**

5. **Home Address** (# and street, city, state, zip)_____

6. **Home Phone** _____ -_____- _____ 7. **Department** _____

8. **Date Hired** (mo./day/yr.) _____/_____/_____ 9. **Job Title** _____

10. **Date of injury or illness** (mo./day/yr.) _____/_____/_____ 11. **Time of injury or illness** _____ ◉ **am** ○ **pm**

12. **Name(s) and Phone(s) of Witness(es)** _____

or ☐ **No Witnesses**

13. **Name of Supervisor Notified** _____ **Date & Time Notified**_____

14. **Did employee receive medical treatment following this incident?** ○ **Yes** ○ **No**

If yes: Medical Provider (name, phone, address) _____

Date _____ **Was employee treated in an emergency room?** ○ **Yes** ○ **No** **Was employee hospitalized overnight?** ○ **Yes** ○ **No**

15. **Describe what caused the injury/symptoms, where you were and what you were doing just before the incident, and what you did immediately following the incident.**

_____

_____

_____

_____

_____

_____

_____

16. **What part(s) of your body were affected? (BE SPECIFIC: for example, right elbow, left knee, right index finger)**

_____

17. **What type of injury did you experience? (BE SPECIFIC: for example, strain, scrape, bruise, laceration)**

_____

18. **Is this an aggravation of a previous injury/symptom?** ○ **Yes** ○ **No** **If yes, last treatment for previous injury:**_____

19. **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 certify the information I have furnished on this form is true, correct, and complete to the best of my knowledge. 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, Hunter Consulting Company. A copy of this form will serve as the original.

_____ _____

Employee's Signature **Date**

I have reviewed this report and acknowledge its receipt.

_____ _____

Supervisor's Signature **Date**

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

Ohio | Bureau of Workers' Compensation

Instructions for Completing the Physician's Report of Work Ability

This form provides important information about the injured worker's ability to work.

- The treating physician must submit this form each time he/she sees the injured worker unless the injured worker has been awarded permanent and total disability, has returned to work without restrictions within seven days of the injury, or is being treated after the treating physician has released him/her to his/her former position without restrictions.
- Please complete this form and provide a copy to the injured worker during his/her office visit. Fax a copy to the appropriate managed care organization (MCO) or to the injured worker's employer if self-insured.
- This form or an equivalent physician-generated document may support a request for temporary total compensation. The equivalent document must contain, at a minimum, the data elements required on this form. If you have submitted previously equivalent data elements that remain the same, indicate the name of the report that reflects the injured worker's current condition, e.g., May 15, 2015, office note.
- You may attach additional medical documentation such as diagnostic test results and a treatment plan to this form.
- Failure to provide complete detailed information may delay or suspend compensation payments to the injured worker.

Instructions

MEDCO-14 submission section: You must select only one of the three choices by selecting the appropriate box. If you previously completed a MEDCO-14 and there are changes, you must indicate the changes in the appropriate section on the form, and select the yes box in that section. For all other sections, you would make no entry, and select the no box.

Employment/occupation section: Please indicate if you have reviewed a description of the injured worker's job held on the date of the injury. Please indicate all sources providing you a description of the injured worker's job. If you do not have a copy of the injured worker's job description, BWC or the MCO can help secure one.

Work status/Injured worker's capabilities section: Please complete this section as accurately and thoroughly as possible, as BWC will use this information to understand the injured worker's work status and help facilitate his/her appropriate and safe return to work either to his/her job held on the date of injury or an alternative job if he/she cannot return to the job held on the date of injury.

3A: Please indicate if the injured worker has any physical or health restrictions **related only to the allowed conditions in the claim.** If there are restrictions, please indicate if the restrictions are permanent or temporary. If there are no related restrictions you should check the release to work box. The date of the exam will be the release to work date.

3B: If there are restrictions **related only to the allowed conditions in the claim,** indicate whether or not the injured worker can return to **the full duties** of his/her job held on the date of injury. If you determine the injured worker cannot return to the full duties of his/her job held on the date of the injury, you must included the date for which you indicate the injured worker could not fully perform the duties of his/her job held on the date of the injury. You must also indicate an estimated date when you believe the injured worker should be able to fully perform the duties of the job held on the date of injury. **It is imperative that you follow all 3B instructions. This will facilitate appropriate processing of the injured worker's claim. Updates to dates in 3B requires 4A to be completed.**

3C: Although an injured worker may not be able to fully return to the job held on the date of injury, understanding the injured worker's capabilities will assist in identifying appropriate and safe work that an injured worker may be able to perform. If an injured worker may return to available and appropriate work with restrictions accommodated, please indicate the possible return to work date. Further, to facilitate BWC's efforts to safely return an injured worker to appropriate work, indicate which of the activities listed in this section, the injured worker can perform. The following definitions apply to the section on Lifting/carrying, Pushing/pulling and Activity with the percentages reflected as they relate to an eight-hour workday:

- Never – 0 percent;
- Occasionally – 1 percent to 33 percent, four to six repetitions per hour;
- Frequently – 34 percent to 66 percent, six to 12 repetitions per hour;
- Continuously – 67 percent to 100 percent, greater than 12 repetitions per hour.

Please note that if the "yes" box is checked in response to the question of whether the injured worker has functional restrictions based only on allowed psychological conditions the MEDCO-16 should be referenced as needed.

We encourage you, in the space provided, to provide any additional information you believe would benefit the injured worker's safety and care relative to any return to work considerations.

Instructions continued on page two

Ohio | Bureau of Workers' Compensation

Instructions for Completing the Physician's Report of Work Ability

Instructions continued

4A: Disability period information section: It is critical that if you answered No to 3B or made changes to dates in 3B this section is fully completed: Please furnish the narrative description of the diagnosis(es), site/location and International Classification of Diseases code for only allowed conditions being treated. You must indicate by checking the appropriate box whether the allowed condition is preventing the injured worker from returning to the job held on the date of injury.

4B: In this area you should list all other relevant conditions that impact treatment of the allowed conditions in the claim.

Clinical findings section: Provide medical rationale for the delay in the injured worker's recovery and the barriers to return to work.

Maximum medical improvement (MMI) section: Provide the MMI date or explain why the injured worker has not reached MMI. Provide the proposed treatment plan, including estimated duration.

Vocational rehabilitation section: If the injured worker is not a candidate for vocational rehabilitation, explain and recommend actions to help the injured worker return to employment.

Treating physician's signature section: Sign and date this form. Your signature indicates you have answered the questions as truthfully and completely as possible.

For more information or assistance

Please contact your local BWC customer service office, or call 1-800-644-6292. You can obtain BWC forms at www.bwc.ohio.gov, at all BWC customer service offices, or by calling 1-800-644-6292 and listening to the options to reach a BWC customer service representative.

Print or Fax

Ohio | Bureau of Workers' Compensation

Physician's Report of Work Ability

Injured worker name			Claim number
Date of injury	Date of last appointment/examination	Date of this appointment/examination	Date of next appointment/examination

MEDCO-14 submission (Select one of the options below.)

1

☐ I have never completed a MEDCO-14. ***Proceed to section 2.***
☐ I have previously completed a MEDCO-14, and all of the information remains the same. ***Proceed to and complete section 8.***
☐ I have previously completed a MEDCO-14, and I am providing updates appropriately checking Yes or No on each section.

Employment/Occupation (Complete this section and proceed to section 3.) (Updates Yes ☐ No ☐)

2

Have you reviewed the description of the injured worker's job held on the date of injury (former position of employment)? Yes ☐ No ☐
If yes - please indicate who (select all sources) provided the job description ☐ Injured worker ☐ Employer ☐ MCO ☐ BWC

Work status/Injured worker's capabilities (Updates Yes ☐ No ☐)

3A

Does the injured worker have any physical or health restrictions related to allowed conditions in the claim? Yes ☐ No ☐
If yes, are the restrictions: ☐ Permanent ☐ Temporary ***Proceed to section 3B.***
If no, please check the box to indicate the injured worker is released to work as of the date of this exam. ☐ ***Proceed to section 8.***

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 ☐ No ☐
If yes, please check the box to indicate that the injured worker is released to work as of the date of this exam. ☐ ***Proceed to section 8.***
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:_____. **Proceed to section 3C.**

3C

Please indicate which of the activities listed below the injured worker can perform (even if the response to 3B is No.)
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: ☐ Left hand ☐ Right hand ☐ Both
The injured worker can perform repetitive wrist motion with: ☐ Left hand ☐ Right hand ☐ Both
The injured worker's dominant hand is: ☐ Left ☐ Right
The injured worker can perform repetitive actions to operate foot controls or motor vehicles with: ☐ Left foot ☐ Right foot ☐ Both
If the injured worker is taking prescribed medications for the allowed conditions in this claim, can the injured worker safely:
*Operate heavy machinery: ☐ Yes ☐ No *Drive: ☐ Yes ☐ No **Perform other critical job tasks as defined by any source listed above in section 2:* ☐ Yes ☐ No

Please indicate the following: N = Never, O = Occasionally, F = Frequently, C = Continuously										Lifting/carrying	N	O	F	C	Pushing/pulling	N	O	F	C
Activity	N	O	F	C	Activity	N	O	F	C	0 - 10 lbs.	☐	☐	☐	☐	0 to 25 lbs.	☐	☐	☐	☐
Bend	☐	☐	☐	☐	Reach above shoulder	☐	☐	☐	☐	11 - 20 lbs.	☐	☐	☐	☐	26 to 40 lbs.	☐	☐	☐	☐
Squat/kneel	☐	☐	☐	☐	Type/keyboard	☐	☐	☐	☐	21 - 40 lbs.	☐	☐	☐	☐	41 to 60 lbs.	☐	☐	☐	☐
Twist/turn	☐	☐	☐	☐	Work with cold substances	☐	☐	☐	☐	41 - 60 lbs.	☐	☐	☐	☐	61 to 100 lbs.	☐	☐	☐	☐
Climb	☐	☐	☐	☐	Work with hot substances	☐	☐	☐	☐	61 - 100 lbs.	☐	☐	☐	☐	100 + lbs.	☐	☐	☐	☐

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 ☐ Continuously ☐ With break
Walk: ____ hours ☐ Continuously ☐ With break Stand: ____ hours ☐ Continuously ☐ With break
Does the injured worker have any functional restrictions based only on allowed psychological conditions? ☐ Yes ☐ 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.

Proceed to section 4.

Injured worker name	Claim number	Date of injury

Disability information (If 3B above is "NO" or dates updated - all 4A fields, including site/location if applicable must be completed) (Updates Yes ☐ No ☐)

4A 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 ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐

4B List all other relevant conditions that impact treatment of the conditions listed above (e.g., co-morbidities or not yet allowed conditions).

Clinical findings: You can reference office notes in lieu of writing clinical findings below. (Updates Yes ☐ No ☐)

5 The injured worker is progressing: ☐ As expected ☐ Better than expected ☐ 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.

Maximum medical improvement (MMI) (Updates Yes ☐ No ☐)

6 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 ☐ No ☐
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.

Vocational rehabilitation (Updates Yes ☐ No ☐)

7 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 ☐ No ☐ If no, please explain why and provide your recommendations to help the injured worker return to employment.

Treating physician signature - mandatory

8 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

Policy # 20005746
Kenyon College is a Self Insured employer
represented by Hunter Consulting Company.

Please send all medical reports and billings to:

Hunter Consulting Company
6600 Clough Pike, 2nd FL
Cincinnati, Ohio 45244

All inquiries should be directed to Hunter Consulting at
(513) 372-8703 or plammers@hunterconsulting.com

Hunter Consulting Company

Workers' Compensation

PriorityRx Prescription Payment Authorization Form

Please keep this Authorization Form on file with script for auditing purposes.

Pharmacist:

This is a temporary workers' comp Rx payment authorization form.

Please contact the M. Joseph Medical Help Desk at 844-DME-AND-Rx (844-363-2637) prior to submitting prescription(s). If you have any questions or experience any issues, please contact M. Joseph Medical Help Desk at 844-DME-AND-Rx (844-363-2637).

Processing information

Processor: EHO (Employer Health Options)
Bin #'s: 004527 (most pharmacies use this number)
Envoy/WebMD = 003241
CVS Condor Code = 15721
Eckerd's/Rite Aid Condor Code = 2185

(These specific pharmacy chains require special numbers to transmit prescriptions. All major chains and most independent pharmacies accept this plan.)

Version: D.O

Patient Information

Last Name: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

First Name: __ __ __ __ __ __ __ __ __ __ __ __ __

Group#: 81207 Sex: Male ☐ Female ☐

Employer: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

ID#/ SS#: __ __ __ __ __ __ __ __ __

D.O.B.: __ __ / __ __ / __ __ __ __

Prior Authorization #: _____ **(retain this # for future use)**

Prior authorization # = DOI in YYMMDD format (Example: July 20, 2014 would be 140720)

Date Sent: _____

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