



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)

Form section for injured worker and injury/disease/death info. Includes fields for personal information, employment details, accident description, and signature.

Form section for treatment info. Includes fields for health-care provider details, diagnosis, and incident-related questions.

Form section for employer info. Includes fields for employer policy details, certification/rejection options, and signature.



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 to each section checked.

**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 work restrictions related to allowed conditions in the claim? Yes  No   
**If yes**, proceed to section 3B.  
**If no** restrictions, please indicate release to work date \_\_\_\_/\_\_\_\_/\_\_\_\_. **Proceed to and complete sections 6 and 8.**

3B If there are work restrictions, can the injured worker return to his/her job held on the date of injury (former position of employment)? Yes  No   
**If yes**, please indicate release to work date: \_\_\_\_/\_\_\_\_/\_\_\_\_. **Proceed to sections 3C, 5, 6, and 8.**  
**If no**, please indicate when the injured worker initially could not do the job held on the date of injury. 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.**

**Please indicate which of the activities listed below the injured worker can perform (even if the response to 3B is "no").**  
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, is the injured worker able to 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				Pushing/pulling					
Activity	N	O	F	C	Activity	N	O	F	C	0 - 10 lbs.	N	O	F	C
Bend					Reach above shoulder					11 - 20 lbs.				
Squat/kneel					Type/keyboard					21 - 40 lbs.				
Twist/turn					Work with cold substances					41 - 60 lbs.				
Climb					Work with hot substances					61 - 100 lbs.				
										100 + lbs.				

3C In an eight-hour workday, how many total hours is the injured worker able to:  
Sit: \_\_\_\_ hours  Continuously  With break    Walk: \_\_\_\_ hours  Continuously  With break    Stand: \_\_\_\_ hours  Continuously  With break  
In the space below please provide any additional information addressing the injured worker's capabilities and/or job accommodations which may not be addressed above. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Injured worker name		Claim number	Date of injury
<b>Disability period information (If 3B above is NO you must address all fields, including site/location if applicable)</b>			(Updates Yes <input type="checkbox"/> No <input type="checkbox"/> )
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.			
4A	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 <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>
4B	List all other relevant conditions that impact treatment of the conditions listed above (e.g., co-morbidities or not yet allowed conditions).		
<b>Clinical findings: Office notes can be referenced in lieu of writing clinical findings below.</b>			(Updates Yes <input type="checkbox"/> No <input type="checkbox"/> )
5	The injured worker is progressing: <input type="checkbox"/> As expected <input type="checkbox"/> Better than expected <input type="checkbox"/> 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.		
<b>Maximum medical improvement (MMI)</b>			
			(Updates Yes <input type="checkbox"/> No <input type="checkbox"/> )
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 <input type="checkbox"/> No <input type="checkbox"/> 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.			
<b>Vocational rehabilitation</b>			(Updates Yes <input type="checkbox"/> No <input type="checkbox"/> )
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 <input type="checkbox"/> No <input type="checkbox"/> If no, please explain why and provide your recommendations to help the injured worker return to employment.		
<b>Treating physician signature - mandatory</b>			
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.		Address, city, state, nine-digit ZIP code, telephone and fax numbers
	Treating physician's name (please print legibly)		
	Treating physician's signature		
BWC provider (Peach) number		Date	