



95-605274

OPC 03
TEAM 01
REP 05

- This form is to be used when the injury causes more than seven calendar days of disability
- This form applies for both medical benefits and long-term compensation
- The EMPLOYEE must complete and file Part 1
- The EMPLOYER must complete and file Part 2
- Incomplete and/or improper completion of this form will result in delayed processing
- Completed form should be sent to: Bureau of Workers' Compensation, Claims Section, 245 No. High St., Columbus, Ohio 43215

GASKINS
ROBIN S.

PART I (Items 1 through 18 are to be completed by the Employee)—PLEASE PRINT OR TYPE

1	Employee's Name Robin S. Gaskins		Telephone No. & Area Code (513) 251-4428	
2	Home Address (Number & Street) 1911 Montross Avenue		Apartment No.	Sex <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female
3	City, State, Zip Code Cincinnati, OH 45214		County Hamilton	Number of Dependents 0
4	Social Security Number 290-66-3512	Birth Date 11/22/62	Age 33	Marital Status Single
5	Your Occupation (job title) Compounder		Work Experience (Yrs & Mos.) in regular occupation 1 year	
6	Employer's Name Tastemakers		Department where you regularly work	
7	Employer's Address (employer's physical location—where employee regularly reports to work) 1199 Edison Drive		At the time of injury were you on: <input type="checkbox"/> Overtime <input type="checkbox"/> Piece Work	
8	City, State, Zip Code Cincinnati, OH 45216		County Hamilton	Employer's Telephone No.
9	List employers you worked for 12 months prior to date of injury. Attach proof of wages received (copy of W-2, letter from employer, etc.) (Attach additional sheet if needed)			
	NAME(S) & ADDRESS(ES)		DATES WORKED FROM TO	TOTAL WAGES
				NO
10	Date of Accident 11-21-95 Time PM	Date Reported to Employer 12/14/95	Last Date Worked	Date Returned to Work 12/14/95 Shift Start 9:00 Shift End 5:00
11	Accident Location (Street, Number, City, State, Zip Code) Tastemakers, 1199 Edison Drive, Cincinnati, OH 45216			Was accident actually on Employer's premises? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
12	Witnesses' Name(s), Address(es), and Phone No(s) (Attach additional sheet if needed)		Were you performing regular occupation at time of accident... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
13	Hospital—if any (Name, Address, City, State, Zip Code) UC Medical Center, 234 Goodman St., Cincinnati, OH 45267			
14	Attending Physician (Name, Address, City, State, Zip Code, Phone #) Dr. James E. Lockey, UC Medical Center, P.O. Box 670458, Cincinnati, OH 45267-0458			
15	Describe Accident in detail describe the events which resulted in the injury. What happened? What were you doing? How did it happen? Be sure to name specific objects, substances and/or machines involved and explain how they were involved. I was formulating Batch No. 51158U which included a large amount of Acetaldehyde vapors came out of the 72 gallon tank between the mixer and the tank and I inhaled the vapors which immediately took me down.			

U. S. GOVERNMENT

NOTE TO EMPLOYER: This C-1 application may also be used in lieu of OSHA 101 when reporting recordable injuries and illnesses to the Federal Government. This form meets OSHA 101 requirements in effect on January 1, 1987. If the injury results in death, a C-2 Death Application must be completed and a copy retained at the employer's place of business.

EMPLOYER'S REPORT

PART II (Items 19 through 27 are to be completed by Employer) (Please Print or Type)

19	Name of Employer (Must be exactly as shown on Certificate)	OSHA Case No.	Area Code—Telephone No.
20	Mailing Address (Number, Street, City, State, Zip Code) (Must be exactly as shown on Certificate)		Federal I.D. or Soc. Sec. No.
21	Nature of Business (farming, coal mining, etc.)	Was Claimant... <input type="checkbox"/> Owner of Business <input type="checkbox"/> Partner <input type="checkbox"/> Member of Firm	
22	Type of Organization (Partnership, Corp., etc.)	BWC USE ONLY CR1-66 OK-03-2 105	
23	The earnings of the injured employee for services rendered at the time of injury were being reported on the payroll reports of...		
24	Risk # Manual # 0285876 41001		
24	If claimant was employed continuously and/or 7 days prior to date of injury—answer 1 & 2. If employed less than 7 days prior to date of injury—answer 3 & 4. 1. Total gross wages for 6 weeks prior to injury, INCLUDE overtime 2. Total gross wages for first 7 days prior to injury, EXCLUDE overtime 3. Claimant's hourly rate of pay the week injury occurred 4. Number of hours claimant was scheduled to work; week of injury		
The following is a worksheet to report the employee's WEEKLY WAGE for the year immediately prior to the date of injury. Use total gross earnings, make no deductions for Social Security, Pensions, Insurance, Unemployment, etc. must have entire year for BWC to compute rate of compensation.			
48	For Week Ending	Amount Earned	# of Days Worked
49	11-27-94	484.99	4-2-95
50	12-4-94	638.93	4-9
51	12-11-94	695.40	4-16
52	12-18-94	791.34	4-23
	12-25-94	4346.97	4-30
	1-1-95	4721.21	5-7
	1-8	764.92	5-14
	1-15	1448.88	5-21
	1-22	587.08	5-28
	1-29	499.67	6-4
	2-5	478.80	6-11
	2-12	486.60	6-18
	2-19	426.08	6-25
	2-26	425.11	7-2
	3-5	481.60	7-9
	3-12	487.93	7-16
	3-19	480.90	7-23
	3-26	622.28	7-30
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