BWC Ohio Workers' Compensation

First Report of an Injury, Occupational Disease or Death

For faster service

Complete as much of all four sections of this form as possible. Type or print in black or blue ink.

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/she is not entitled, is subject to felony criminal prosecution for fraud.

Injured Worker Info

Last Name, First Name, Middle Initial: Walker Clifford H
Social Security Number: 294-46-8665
Marital Status: ☐ Single ☒ Married ☐ Divorced ☐ Separated ☐ Widowed
Date of Birth: 11-23-46
Home Mailing Address: 2018 Thimbleglen Row
Sex: ☒ Male ☐ Female
Number of Dependents: 1
City: Cincinnati State: OH 9-digit ZIP Code: 45251
Country if different than U.S.A.:
Department Name: Warehouse
Wage Rate: X $ 17.06 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 6:30 To 3 P
Have you been offered or do you expect to receive payment for this claim from anyone other than the Ohio Bureau of Workers' Compensation or the employer? ☐ YES ☒ NO
Occupation or Job Title: Material Handler

Injured Worker 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 of medical, psychological, and/or psychiatric information that is related to 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.

Telephone Number: 385-5319
Work Number: 513-948-3432
Injured Worker Signature: [signature]
Date: 2-3-99

Injury/Disease/Death Info

Date of Injury/Disease: Started — 10/83/86 MD
Time of Injury: ☐ AM ☐ PM
If fatal, give date of death:
Date Last Worked:
Date Returned to Work:
Accident Location (street address): 100 E 69th Street
Date Hired: 03/08/1990
State Where Hired: OH
City: Cincinnati
State: OH
Date Employer Notified: 11-02-95
Was place of accident or exposure on employer's premises? ☒ YES ☐ NO
Description of Accident (Describe the sequence of events that directly injured the employee, or caused the disease or death): Decreasing Pulmonary Function Test results due to exposure to chemical products used in production
Type of Injury/Disease and Part(s) of Body Affected (For example: sprain of lower left back, etc.): Respiratory system

Treatment Info

Physician/Health-Care Provider Name: James E Lockey MD + Robert P. Baughman MD
Telephone Number: (513) 584-1034
Fax Number: (513) 584-1010
Initial Treatment Date: 9/18/95
Street Address: UCMC
City: Cincinnati
State: OH
9-digit ZIP Code: 45267-0458
Diagnosis(es) include ICD-9 Code(s):
Provider Signature:
BWC Provider Number:
Date:

Employment Info

Employer Name: Givaudan Roure Flavors
Policy Number:
☐ Employer is Self-insuring
☐ Injured Worker is Owner/Partner/Member of Firm
Mailing Address (Number and Street, City or Town, State, and ZIP Code):
Location, if different from mailing address: 100 E 69th St - Cincinnati OH 45216
County: Hamilton
Manual Number:
Telephone Number: (513) 948-8000
Fax Number: (513) 948-
Federal ID number:

☐ 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 following reason(s) below:

FOR SELF-INSURING EMPLOYERS ONLY: ☐ CLARIFICATION - The employer clarifies and allows the claim for the condition(s) below:

Employer Signature and Title:
Date:
OSHA Case Number:

FROI-1 (Combines C-1, C-2, C-3, C-6, C-50, C-51, OD-1, OD-1-22) BWC-1101 (Rev. 6/26/97) This form meets OSHA 101 requirements.

EMPLOYEE CONFIDENTIAL: MEDICAL & EMPLOYMENT INFORMATION TM004103