BASIC OHIO WORKERS' COMPENSATION OUTLINE

1. What is workers comp in Ohio?
    a. Ohio Revised Code Chapter 4123.01 through 4123.94
    b. Bureau of Workers Compensation https://info.bwc.ohio.gov/home
    c. Industrial Commission of Ohio https://www.ic.ohio.gov/index.html

2. What are the first steps an IW should take? (report, medical attention, file claim)
    a. Treating with a BWC Certified Doctor / Differences with Insurance

3. Is this employer state-fund or self-insuring? What is the difference?

4. Who Participates in filing a workers' compensation claim?
    a. Injured Worker
        i. Medical only claim or lost-time claims:
            1. What is FWW and AWW?
                a. Full Weekly Wage Calculation and Average Weekly wage Calculation
        ii. Nature of Injury:
            1. physical vs. psychological
            2. direct causation, flow-through injury, substantial aggravation of a pre-existing condition, occupational disease
    b. Employer
    c. 2 AGENCIES
        i. BWC
        ii. The Ohio Industrial Commission
    d. Managed Care Organization
    e. Third-Party Administrators

5. What is each participant responsible for?

6. Filing a Claim
    a. R2-IW Authorized Rep
    b. R1-Employer Authorized Rep
    c. C101-Release of Medical
    d. Dates/Statutes Associated
    e. FROI=First Report of Injury, Disease or Death
    f. Additional: Consent to Release Information, Direct Deposit Application, Presumption of Causation for firefighter Cancer(C-265)

7. Temporary Total Benefit

a. What is it?
b. Who is entitled to it?
c. C84 Form by IW
d. Physician's Report of Work Ability/MEDCO 14

8. Wage Loss
    a. What is it?
    b. Who is entitled to it?
    c. Application C-140
        i. Wage Loss Statement for Job Search
        ii. Employer report of Employee Earnings

9. Schedule Loss
    a. Who is entitled to the benefit?
    b. C-86 motion
    c. Amputation/Loss of Use Diagram C-196

10. Percentage of Permanent Partial
    a. Who is entitled to the benefit?
    b. Application for Determination and/or Increase in Award
    c. Objection to Tentative Order awarding Permanent Partial Disability

11. Permanent Total Disability
    a. Who is entitled to the benefit?
    b. Application
    c. PTD rate calculation

12. Lump Sum Settlement
    a. Who is entitled to the benefit?
    b. Forms: C240
    c. Medical History
    d. PTD Death settlement acknowledgement and waiver Full and Final settlement
    e. Notice of Intent to Settle C-512

13. Lump Sum Advancement
    a. Who is entitled to it?
    b. Application-C32

14. How do medical treatments and benefits get approved?

15. How does the attorney get paid for services?
    a. Hearings
    b. IW Benefits
    c. Settlement
    d. Litigation

16. Fee Agreement Decisions

17. Nature of Admin Hearing Process
    a. File for a benefit: Application / Motion
        i. If Denied: ADR Appeal or Motion to Appeal
    b. ADR/Motion Appeal to BWC to have a Bureau of Workers' Compensation Hearing Set to Hear the Matter
        i. Nature of hearing
        ii. Denial
    c. Appeal to District Hearing Officer Hearing
        i. Nature of Hearing
        ii. Denial
    d. Appeal to Staff Hearing Officer Hearing
        i. Nature of hearing
        ii. Denial
    e. Potential Appeal to Commissioners for Reconsideration
        i. Nature of Hearing
    f. Appeal into Court of Common Pleas
    g. Filing a Mandamus Action in the Tenth District Court of Appeals

18. Nature of Common Pleas Filings/Litigating an Issue
    a. What can and cannot be taken to court?
    b. Statute of Limitations

19. How does receiving workers' comp benefits?

20. Other Ancillary Issues in Workers' Compensation
    a. Subrogation
    b. VSSR-Violations of Specific Safety Requirements

Section 4123.21 | Injunction shall not issue suspending or restraining actions.

Ohio Revised Code

Title 41 Labor and Industry

Chapter 4123 Workers' Compensation

Effective:
November 3, 1989
Latest Legislation:
House Bill 222 - 118th General Assembly
PDF:
Download Authenticated PDF

No injunction shall issue suspending or restraining any order, classification, or rate adopted by the industrial commission or the bureau of workers' compensation, or any action of the auditor of state, treasurer of state, attorney general, or the county auditor or county treasurer of any county, required to be taken by them or any of them by this chapter. This section does not effect any right or defense in any action brought by the commission, the bureau, or the state in pursuance of authority contained in this chapter.

FULL CASE AT LINK BELOW

THE **STATE EX REL. DILLON, APPELLANT, v. INDUSTRIAL COMMISSION OF OHIO** ET AL., APPELLEES. [Cite as *State ex rel. Dillon v. Indus. Comm.*, 2024-Ohio-744.]

https://www.supremecourt.ohio.gov/rod/docs/pdf/0/2024/2024-Ohio-744.pdf

Examples of Forms BELOW

All forms:

https://info.bwc.ohio.gov/forms-and-publications

R-1: Representing Employer
R-2: Representing Injured Worker/Employee
C-9: Requesting medical treatment
C-11: Appeal to denial of medical treatment
C-86: Motion
C-84: Injured Worker requesting time off due to injury
MEDCO14: Physician of Record for IW stating IW cannot work/or has restrictions

Bureau of Workers' Compensation

Employer Authorized Representative (R-1)

The employer must complete this form in its entirety and fax it to 1-614-621-3437.
The form is available online at bwc.ohio.gov.

Claimant information		
Claimant name	Date of injury	Claim number

Employer information			
Employer name		Employer policy number	
Address			
City	State	ZIP code	
Email address, if available		Phone number	

Representative information		
*Your representative **must** have a BWC representative identification number prior to being designated as an authorized representative.		
Representative/Firm name		
Representative BWC ID number*		Phone number
Representative street address		
City	State	ZIP code
Email address, if available		

Authorization	
I hereby authorize the above representative to represent me in the above claim before the Ohio Bureau of Workers' Compensation and the Ohio Industrial Commission of Ohio. This authorization also entitles this representative to automatically receive correspondence generated in the above claim file.	
Signature of employer official granting this authorization	Printed name
	Date of authorization

Bureau of Workers' Compensation

Claimant Authorized Representative (R-2)

Complete this form in its entirety and fax it to 1-614-621-3437, file the form at the Representative Desk in the William Green building, or send it to the BWC customer service office where your claim is assigned.

The form is available online at bwc.ohio.gov.

Claimant information

Claimant name	Date of injury	Claim number
Claimant address		
City	State	ZIP code
Email address, if available	Phone number	

Representative information

*You may have only one legal representative (one attorney or one law firm) and one union representative.
Your representative **must have a BWC representative identification number prior to being designated as an authorized representative.

Representative/Firm name*		
Representative BWC ID number**	Phone number	
Representative street address		
City	State	ZIP code
Email address, if available		

Authorization

I authorize the above to be my authorized representative. The authorization entitles the representative access to my complete claim file, including medical and/or other information contained therein, and to receive correspondence generated in the above claim.

I further understand that:

- If I designate an attorney or law firm, BWC will remove any previously designated attorney or law firm as legal authorized representative, and it is my responsibility to notify the former legal representatives of the change;
- If I have previously authorized an individual in this claim to receive my workers' compensation check, **I understand that, if desired, I must cancel the previous authorization separately in writing.**

The authorization above is being given to a:

☐ Attorney ☐ Law firm ☐ Union representative ☐ Other (Please explain.)

Signature of claimant	Printed name
	Date of authorization

Bureau of Workers' Compensation

Request for Medical Service Reimbursement or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease

• **Instructions for completing the C-9 on reverse side.**

Fax note

To	Toll-free fax number	Phone number
From	Phone number	Fax number

IW

❶ Injured worker name	Claim number	Date of injury

II. Requested services

❷ Treating diagnosis for this request to include body part/levels.	❸ Date service begins	Date service ends	Date of last exam or treatment

❹ Requested services with CPT/HCPCS codes (required)	Frequency	Duration
1.		
2.		
3.		
4.		

❺ Provide the two-digit facility site of service code as used by the Centers for Medicare and Medicaid Services (CMS), if applicable.

III. Additional conditions

If you are recommending additional conditions to the claim, supporting documentation is required. **You may not use the C9 to request additional conditions for claims of self-insuring employers.**

❻ Provide diagnosis (narrative description only), and location and site for conditions you are requesting.

❼ In your opinion, based on the history from the injured worker, your clinical evaluation and expertise, is the diagnosis or condition causally related, either directly or proximately, to the alleged industrial accident or exposure?

☐ Yes, please attach explanation. ☐ No, please attach explanation.

IV. Physician/provider information

❽ Identify the provider who will render the requested services and the address where he or she will provide the services (required). Travel reimbursement may not be authorized when the service provided is available within 45 miles round trip from the injured worker's residence.

❾ Requesting physician/provider name and address (please print, type, or stamp)	❿ Physician/provider/authorized signature (required)	☐ POR ☐ Not POR – but treating physician/provider
	Individual BWC provider number (required)	Date (M/D/Y) (required)

I certify the above information 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, under appropriate criminal provisions, be punished by a fine, imprisonment, or both.

V. MCO/Self-insuring employer decision

Managed care organization (MCO) – If this page is not faxed or mailed back to the submitting physician/provider within three business days of receipt or within five business days of receipt of information requested on the C-9-A, BWC shall deem the authorization for treatment granted subject to our policy, excluding retroactive requests.

☐ **Approved with disclaimer** – This medical payment authorization is based upon a claim or additional condition that BWC/IC is considering as of the date of the MCO's signature. If the claim or additional condition is ultimately disallowed, BWC may not cover the services/supplies to which this medical payment authorization applies. These services/supplies may be the responsibility of the injured worker (for MCO use only).

☐ Approved Date service begins Date service ends

☐ Amended approval: _____

☐ Denied explanation: _____

You may file disputes to the decision in writing with supporting documentation to the MCO.

☐ Pending: The documentation requested must be submitted to the MCO case manager within 10 business days to allow for a treatment decision. Failure to respond may result in denial.

☐ Claim inactive: MCO cannot make a decision on this request, further investigation required. BWC will issue a decision in writing within 28 days.

☐ Withdrawn ☐ Dismissed

BWC claim status: ☐ Allowed ☐ Denied ☐ Pending

MCO company/Self-insuring employer name (please print, type or stamp)	MCO name and signature (print, type or stamp and sign)		
	MCO number	Telephone number	Date

Self-insuring employer

Self-insuring employer use only — Fax or mail this page to the submitting physician/provider within 10 days of receipt or the authorization for treatment shall be deemed granted, per Ohio Administrative Code 4123-19-03 (K)(5).

Self-insuring employer signature	Date

BWC-1113 (Rev. Dec. 11, 2023)
C-9 (Combines C-1-A & C-161)

Bureau of Workers' Compensation

ADR Appeal to the MCO Medical Treatment/Service Decision

Instructions

- Please print or type.
- Complete this form to the best of your knowledge.
- This form may also be used to withdraw this appeal by completing the **withdraw appeal section** in the instructions.
- The injured worker, employer, authorized representatives or provider must file this appeal with the injured worker's managed care organization (MCO).
- Use this form to appeal the MCO's medical treatment/service decision and to start the alternative dispute resolution (ADR) process.
- You must file your appeal with the MCO within 14 days of receipt of the written notice of the MCO's initial medical treatment/service decision.

The injured worker name and BWC claim number are mandatory.

Injured worker name	BWC claim number

Appealed by: (check appropriate box)

☐ Injured worker name		Telephone number
☐ Injured worker representative name	Representative ID number	Telephone number
☐ Employer name	Contact person	Telephone number
☐ Employer representative name	Representative ID number	Telephone number
☐ Provider name	Specialty	Telephone number

Date of MCO initial decision letter:

Date of receipt of MCO initial decision:

Was this treatment/service decision ☐ Denied ☐ Approved ☐ Amended

Specify medical treatment/service you wish to appeal.

Enter start date of requested treatment: _____	Enter total number of treatments: _____ ☐ per week for _____ weeks OR ☐ per month for _____ months

Give reason for the appeal. Please be specific, include any relevant information, any new evidence that will assist in approval of your appeal. (Attach additional documentation if necessary.)

Signature of party filing appeal	Date

Withdraw appeal

I withdraw the above referenced appeal

_____ (Signature of party withdrawing appeal)

_____ (Date)

Bureau of Workers' Compensation

Motion (C-86)

Instructions

Section I Injured worker information

Complete demographic information.

Section II Specific request to be considered

You must specifically state the requested action as noted below.

- For an additional condition(s), please state the diagnosis of the medical condition(s) you wish BWC or the Industrial Commission of Ohio (IC) to consider. If requesting a psychiatric or psychological condition, please include the statement below. This statement must be signed and dated by the injured worker.

  I am aware this motion is requesting that this claim be additionally recognized for a psychiatric or psychological condition that is a result of the injury for which the claim is allowed.

  Injured worker's signature _____ *Date* _____

- For temporary total (TT) compensation, please state the period for which you are requesting TT.
- For wage adjustment, please state the current wage amount and the amount you want adjusted.
- For a self-insured claim dispute, please state the issue you dispute, such as payment of medical bills compensation, authorization of treatment, allowance of medical condition, etc.
- For any other issue, please state in detail the specific action you wish BWC or the IC to consider.
- **Note: Do not use this form to file an appeal to a BWC or IC hearing order. Use Notice of Appeal (IC-12).**

Section III Supporting evidence

You must submit or reference evidence to support the requested action as noted below.

- For an additional condition(s), please indicate documentation on file that supports your request, or attach medical documentation such as medical reports, which includes a physician statement addressing the causal relationship between the requested diagnosis and the work-related injury, diagnostic test results, radiology exam results, operative reports, etc.
  - If you are requesting the addition of a pre-existing condition that has been aggravated by the work-related injury, you must clearly identify it as an aggravation or substantial aggravation (depending on the date of injury) of the specific pre-existing condition.
  - If the date of injury is on or after Aug. 25, 2006, (substantial aggravation), you must provide objective diagnostic findings, objective clinical findings, or objective test results that show the specific pre-existing condition has substantially worsened due to the work-related injury.
  - If the date of injury is before Aug. 25, 2006, you must provide objective or subjective evidence or both that show aggravation, i.e., some real adverse effect on the specific pre-existing condition.
- For TT, please include a completed and signed *Request for Temporary Total Compensation* (C-84), *Physician's Report of Work Ability* (MEDCO-14) or equivalent form, and any additional evidence to support your request.
- For a wage adjustment, please indicate documentation on file that supports your request, or attach earning statements, pay stubs, a wage statement form, a payroll report, a W-2 or other tax forms, etc.
- For a self-insured claim dispute, please indicate documentation on file that supports your request, or attach copies of authorization requests, medical bills, or other evidence.
- For any other request, please indicate documentation on file that supports your request or attach specific evidence that supports the action you wish taken.

Bureau of Workers' Compensation

Motion (C-86)

Instructions

- Parties to the claim requesting a decision by BWC or the Ohio Industrial Commission (IC) must use this form if any other form or application does not apply. For a complete list of forms visit bwc.ohio.gov, or call BWC at **1-800-644-6292.**
- **Attention health-care providers: Do not use this form.** Health-care providers must use the *Physician's Request for Medical Service or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease*

Section I Injured worker information

Injured worker name		Claim number	
Street address	City	State	ZIP code

Section II Specific request to be considered

This *Motion* is a request to consider the following: (You must specifically state the requested action as outlined on the instructions page.)

Section III Supporting evidence

In support of this *Motion,* the following evidence is included: (You must submit or reference evidence with this form to support the requested action as outlined on the instructions page.)

Signature

Certificate of Service: By signing below, I certify I have provided a copy of this *Motion* to all parties and representatives to the claim. Parties to the claim include the injured worker, employer and/or their authorized representatives, and BWC.

Signature of applicant	Date

Please indicate the party filing the form by checking the appropriate box.

☐ Injured worker ☐ Employer ☐ Authorized representative ☐ Administrator of the Ohio Bureau of Workers' Compensation

Bureau of Workers' Compensation

Request for Temporary Total Compensation

Injured worker demographics

1

Name		Claim number		Date of injury
Address	City		State	Nine-digit ZIP code
Email address (optional)		Home phone number _ _		Cell phone number _ _

Disability information

2

- Is this application requesting a new period of temporary total compensation or an extension? ☐ New ☐ Extension
- If this is a new period, what was the last date worked due to the current period of work-related disability? ____/____/____
- List all providers **currently** treating you for this work-related disability claim. _____

Employment information

3

What was your occupation at the time of the injury/disease? _____

- Do you have a job to return to? ☐ Yes ☐ No ☐ I don't know
  - o If yes, who is your employer? _____
  - o If yes, does your employer offer modified (light-duty) work? ☐ Yes ☐ No ☐ I don't know
  - o If yes, do you feel capable of performing any of your job duties at this time? ☐ Yes ☐ No

    If yes, what duties? _____

Working includes full or part-time, self-employment, income-producing hobbies, commission work, or unpaid activities that are not minimal and directly earn income for someone else.

- Are you currently working in any capacity (as defined above)? ☐ Yes ☐ No
  - o If yes, who is your employer? _____
- Have you previously worked in any capacity (as defined above) during this requested period of disability? ☐ Yes ☐ No
  - o If yes, who is your employer? _____
  - o If no, when was the last date you worked anywhere? ____/____/____ Reason for leaving _____
- What do you feel is preventing you from returning to work at this time? Please describe physical, employment and personal barriers.

Vocational rehabilitation information

4

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.

- If appropriate, would you consider participating in vocational rehabilitation? ☐ Yes ☐ No If no, why not? _____

Benefits/earnings received or requested during the period of disability

5

Type of benefit	Receiving	Beginning date of benefit
Unemployment **If yes, from which state are you receiving benefits?** _____	☐ Yes ☐ No	
Social Security retirement	☐ Yes ☐ No	
Public assistance **If yes, include case number:** _____	☐ Yes ☐ No	
Sick leave **If yes, name of company paying the benefit:** _____	☐ Yes ☐ No	
Wage/salary continuation **If yes, name of company paying the benefit:** _____	☐ Yes ☐ No	
Disability **If yes, name of company paying the benefit:** _____	☐ Yes ☐ No	
Earnings **(to include full or part time, self employment, income-producing hobbies or commission work)** **If yes, name of employer and job duties.** _____	☐ Yes ☐ No	

Injured worker signature

6

I understand I am not permitted to work while receiving temporary total compensation. I have answered the foregoing questions truthfully and completely. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by BWC or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine, imprisonment or both.

Signature	Date

Bureau of Workers' Compensation

Physician's Report of Work Ability (MEDCO-14)

Instructions

- Use this form to provide detailed information about the injured worker's ability to work. Add comments to Section 4 or attach additional information as necessary. BWC uses the information to support a request for temporary total compensation.
- The treating physician must submit this form each time they see the injured worker unless they:
  - Have been awarded permanent and total disability.
  - Have returned to work without restrictions within seven days of the injury.
  - Are being treated after the treating physician has released them to their former position of employment (i.e., full duty job) held on the date of injury without restrictions.
- While you may use an equivalent physician-generated document (e.g., office notes, treatment plan) to the MEDCO-14, it must contain, at a minimum, the required data elements. If you've previously submitted equivalent data, indicate the date of the report on the form (e.g., 5/15/2021, office note).

Note: Physician assistants and nurse practitioners may complete this form; however, they may only certify temporary disability for the first six weeks after the date of injury. Subsequent periods of temporary disability require a co-signature by the treating physician.

- Fax form to the managed care organization if the employer is state-fund or to the employer if self-insured.
- **Important:** Failure to provide complete information may delay compensation payments to the injured worker.

Injured worker name	Claim number	Date of injury

Date of ***last*** appointment/examination	Date of ***this*** appointment/examination	Date of ***next*** appointment/examination

1 Submission type (Select one of the options below.)

- ☐ Initial MEDCO-14. ***Proceed to Section 2.***
- ☐ Subsequent MEDCO-14, **no** changes ***Proceed to Section 6.***
- ☐ Subsequent MEDCO-14, **with changes.** Check the appropriate box "Reporting changes from the last evaluation" or "No changes" in each section.

2 Job description and work status ☐ Reporting changes from last evaluation ☐ No changes

- Have you reviewed the injured worker's job description? ☐ Yes ☐ No
  - **If yes,** who provided the job description ☐ Injured worker ☐ Employer ☐ MCO/BWC
- Does the injured worker have any physical or health restrictions **related to the allowed conditions in the claim** on the date of this exam? ☐ Yes ☐ No
  - **If yes,** are the restrictions: ☐ Permanent? ☐ Temporary?
  - **If no,** check the box to indicate the injured worker is released to return to full duty as of the date of this exam. ☐ ***Proceed to Section 6.***
- If there are restrictions, can the injured worker return to their full duty job held on the date of injury as of the date of this exam? ☐ Yes ☐ No
  - **If yes, *Proceed to Section 6.***
  - **If no,** provide date restrictions began ____/____/____ and estimated full duty return-to-work date ____/____/____. ***Proceed to Section 3.***

3 Disability information ☐ Reporting changes from last evaluation ☐ No changes

Complete the chart below for all **work-related allowed conditions being treated**.

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

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

Injured worker name	Claim number	Date of injury

4 Abilities, clinical findings, and recovery progression ☐ Reporting changes from last evaluation ☐ No changes

- Is the Injured worker taking prescribed medication for the allowed conditions that may be a safety hazard? ☐ Yes ☐ No
- Dominant hand: ☐ Right ☐ Left
- Circle the injured worker's physical abilities for the activities in the chart below and provide comments as necessary.

Frequency scale	Strength level (lbs.)	Body side indicator
N = Never **S** = Seldom 0-1 hour **O** = Occasional 1-3 hours **F** = Frequent 3-6 hours **C** = Constant 6-8 hours	**S** = Sedentary 0-10 **L**= Light 0-20 **M** = Medium 0-50 **H** = Heavy 0-100 **VH** = Very heavy >100	**L** = Left **R** = Right **B** = Both *Indicate **limitations ONLY**

Activity	Frequency	Activity	Strength	Frequency	Activity	Side
Sit	N S O F C	Floor lift (0-17")	S L M H VH	N S O F C	Front/Lateral reach	L R B
Stand/Walk	N S O F C	Knee lift (18-29")	S L M H VH	N S O F C	Overhead reach	L R B
Climb stairs	N S O F C	Waist lift (30-36")	S L M H VH	N S O F C	Wrist flex/extension	L R B
Squat/Kneel	N S O F C	Chest lift (37-60")	S L M H VH	N S O F C	Grasp	L R B
Crawl	N S O F C	Overhead lift (>60")	S L M H VH	N S O F C	Finger manipulation	L R B
Twist	N S O F C	Push/Pull	S L M H VH	N S O F C	Keyboarding	L R B
Bend/Stoop	N S O F C	Carry	S L M H VH	N S O F C	Operate foot controls	L R B

- Injured worker can work _____hours per day and _____ hours per week.
- Are there any functional restrictions based only on the allowed psychological conditions? ☐ Yes ☐ No
  - If yes, describe any functional restrictions in comments below and reference the MEDCO-16 as needed.
- Provide your clinical and objective findings supporting your medical opinion. List barriers to return to work, reason(s) for delayed recovery, and proposed treatment plan (e.g., modalities, therapies, surgery), including estimated duration of each treatment or indicate if all or part of this information is in office notes (include date(s) of notes).

Comments:

Health and Behavioral Assessment: (HBA evaluates cognitive, emotional, social, and behavioral barriers that might impact physical health problems and treatments which are associated with the allowed physical injury in the claim.)

- Is the injured worker's recovery not progressing, or progressing slower than expected? ☐ Yes ☐ No
- Do cognitive, emotional, social, or behavioral barriers exist that may be interfering with expected healing? ☐ Yes ☐ No

Vocational rehabilitation is a voluntary program for an eligible injured worker who needs assistance to remain at work or return to work. Is the injured worker currently able to participate in a vocational rehabilitation program? ☐ Yes ☐ No

5 Maximum medical improvement (MMI) status ☐ Reporting changes from last evaluation ☐ No changes

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: ____/____/____. ***Note:*** *An injured worker may need supportive treatment to maintain his or her level of function after reaching MMI. So, periodic medical treatment may still be requested and, if approved, provided.*

6 Treating physician's signature – mandatory (See exceptions at the top of the form.)

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 (Print legibly.)		Address, city, state, nine-digit ZIP code	
Treating physician's signature			
BWC provider (PEACH) number	Date	Telephone number	Fax number