

**OHIO MILITARY RESERVE**



**Regulation 600-10**

**INJURY  
ACCIDENT  
REPORTING  
AND  
WORKER'S  
COMPENSATION  
CLAIMS**

Headquarters, Ohio Military Reserve  
Office of the Staff Judge Advocate  
1000 Lawrence Road  
Camp Perry Training Site  
Port Clinton, Ohio  
43452-9578

**01 February 2001**

# Summary of Changes

---

The changes noted herein are only those changes of significance or which effect ongoing operations. Changes in terminology, organization or other routine matters are not reflected.

OHMR Regulation 600-10

This regulation is a completely new document. It replaces the interim OHMR Policy 99-05 of the same title. The policy was adopted as regulation without changes.

**Headquarters  
Ohio Military Reserve  
Camp Perry Training Site  
Port Clinton, Ohio  
01 February 2001**

**Injury Accident Incident Reporting  
and  
Worker's Compensation Claims**

---

By Order of the Governor:

CHARLES E. HOLLAR  
*Brigadier General, Ohio Military Reserve  
Deputy Commander*

Official:

RICHARD B. IOTT  
*Lieutenant Colonel, Ohio Military Reserve  
Secretary to the General Staff*

---

**Supersedes.** This regulation supersedes OHMR Policy 99-05 of the same name.

**Applicability.** This regulation applies to all personnel of the Ohio Military Reserve.

**Supplementation.** Supplementation of this regulation and establishment of command and local policies is strictly prohibited.

**Suggested Improvements.** Suggested improvements which may be considered for this regulation should be forwarded in writing to the proponent agency of this regulation, the Office of the Staff Judge Advocate, OHMR-SJA, Camp Perry Training Site, 1000 Lawrence Avenue, Port Clinton, Ohio, 43452-9578.

**Summary.** This regulation provides the procedure and requirements to be followed for reporting accidents and filing Workers Compensation claims.

---

<b>Contents</b>	<b>Paragraph</b>	<b>Contents</b>
Purpose	1	Appendix A
Responsibility	2	OHMR Form 1101, Injury Accident Incident Report
General	3	
Exceptions	4	Appendix B
Questions	5	Bureau of Workers' Compensation Form FROI-1 (BWC-1101)

---

1. Purpose.  
This policy provides the procedures and requirements to be followed by personnel of the Ohio Military Reserve when involved in an injury to a person and/or when such injury may involve the filing of a workers' compensation claim.
2. Responsibility.  
This regulation will be applied by all commanders and will be administered by the Corps Staff Judge Advocate.
3. General.  
a) Whenever an injury to a person has occurred, such incident shall be immediately (or as

- soon as reasonably possible) reported to the individual's unit commander.
- b) The unit commander shall be primarily responsible for preparing an Injury Accident Incident Report, OHMR Form 1101 (see Appendix A). If such form is not available, the report must include, at a minimum, the following:
    - 1) full name of individual; with home address, home telephone number, business telephone number, and social security number.
    - 2) rank, unit and duty assignment.
    - 3) date, time and place of accident.
    - 4) description of accident, including treatment if applicable.
    - 5) names, addresses and, to the extent possible, statements of witnesses.

6) copies of applicable orders.

c) In the event the accident occurs at Annual Training, the incident should be reported to the Provost Marshal's Office and that office will be primarily responsible for preparing the incident report as outlined in paragraph 2b above.

d) The incident report will be forwarded to the respective Brigade Commander for approval endorsement. If HHD individual is involved, the report is forwarded to the HHD DC (A&S) or commander's delegate.

e) After approval endorsement, copies of the report are distributed as follows:

1) one copy is returned for retainment at the unit level,

2) one copy retained by the endorsing authority,

3) one copy forwarded to OHMR-G1 for retainment,

4) one copy forwarded to OHMR-SJA for retainment.

f) As soon as reasonably practicable, the injured individual will complete a Bureau of Workers' Compensation Form FROI-1 (BWC-1101, see sample

at Appendix B). After completion, the original Form FROI-1 will be forwarded to OHMR-SJA. Do not mail the form directly to the Bureau of Workers' Compensation as directed on the form; this may delay or jeopardize processing. Any questions pertaining to the completion of Form FROI-1 should be directed to OHMR-SJA. A copy of Form FROI-1 shall be retained in the individual's local Military Personnel Records Jacket (MPRJ).

g) OHMR-SJA will be responsible for processing the individual's Form FROI-1, and such other documents as the SJA deems necessary, to the Adjutant General's Department, Columbus, Ohio for appropriate processing with the Bureau of Workers' Compensation.

3. Exceptions. Any deviation from compliance with paragraphs 2a through 2g must be approved by the Corps Commander, Deputy Commander (A&S) or Corps SJA.

4. Questions. Any questions regarding implementation of this policy are to be directed to OHMR-SJA.

APPENDIX A (OHMR Form 1101, Injury Accident Incident Report) to OHMR Regulation 600-10

<b>INJURY ACCIDENT INCIDENT REPORT</b>			DATE OF REPORT:	
<b>PERSON INJURED</b> <i>(complete separate form for each person injured)</i>				
NAME: <i>(last, first, MI)</i>		RANK/GRADE:	UNIT/DUTY ASSIGNMENT:	
HOME ADDRESS:		SSN:	DATE OF BIRTH:	
		HOME PHONE:	BUSINESS PHONE:	
<b>DESCRIPTION OF INJURY ACCIDENT</b>				
LINE OF DUTY: <i>(circle one)</i> YES      NO <i>(this box must be initialed by endorser)</i>		FATAL: <i>(circle one)</i> YES      NO		DATE OF INJURY ACCIDENT:
TIME OF INJURY ACCIDENT:				
PLACE WHERE INJURY ACCIDENT OCCURRED:				
DESCRIPTION OF INJURY ACCIDENT, INCLUDING TREATMENT, IF APPLICABLE: <i>(may be continued on back)</i>				
<b>WITNESS #1</b>			<b>WITNESS #2</b>	
NAME:			NAME:	
ADDRESS:			ADDRESS:	
HOME PHONE:	BUSINESS PHONE:		HOME PHONE:	BUSINESS PHONE:
STATEMENT: <i>(may be continued on back)</i>			STATEMENT: <i>(may be continued on back)</i>	
<b>PERSON COMPLETING REPORT</b>				
NAME:		RANK/GRADE:	UNIT/DUTY ASSIGNMENT:	
CONTACT ADDRESS:			HOME PHONE:	
			WORK PHONE:	
			SIGNATURE:	
<b>ENDORSEMENT</b> <i>(line of duty box above must also be initialed by endorser to indicate approval)</i>				
NAME:		RANK/GRADE:	UNIT/DUTY ASSIGNMENT:	DATE:
<b>INSTRUCTIONS:</b>				
<p>1. Whenever an injury accident has occurred, such incident shall be immediately (or as soon as reasonably possible) reported to the individual's unit commander. The commander shall be primarily responsible for preparing this report promptly. Copies of applicable orders must be attached.</p> <p>2. The completed report will be forwarded to the respective Brigade Commander for approval endorsement. Line of duty box must be initialed by endorser.</p> <p>3. After approval endorsement, one copy is retained at unit level, one copy retained by the endorsing authority, one copy forwarded to OHMR-G1 and one copy to OHMR-SJA.</p>				

**Attachment B to OHMR Policy 99-05**



**First Report of an Injury, Occupational Disease or Death**

**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.

(R.C. 2913.48)

or faster service

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

<b>Injured Worker Info.</b>	Last Name, First Name, Middle Initial			Social Security Number		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Date of Birth	
	Home Mailing Address				Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Number of Dependents		
	City		State	9-digit ZIP Code		Country if different than U.S.A.		Department Name	
	Wage Rate \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Month <input type="checkbox"/> Week		What days of the week do you usually work? <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thur <input type="checkbox"/> Fri <input type="checkbox"/> Sat				Regular Work Hours From _____ To _____		
	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? <input type="checkbox"/> YES <input type="checkbox"/> NO						Occupation or Job Title		
	<b>Benefit Application/Medical Release</b> 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						Telephone Number		Work Number
						Injured Worker Signature		Date	

<b>Injury/Disease/Death Info.</b>	Date of Injury/Disease		Time of Injury <input type="checkbox"/> AM <input type="checkbox"/> PM		If fatal, give date of death		Date Last Worked		Date Returned to Work	
	Accident Location (street address)				Date Hired		State Where Hired		Date Employer Notified	
	City		State		Was place of accident or exposure on employer's premises? <input type="checkbox"/> YES <input type="checkbox"/> NO					
	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, etc.)			

<b>Treatment Info.</b>	Physician/Health-Care Provider Name			Telephone Number ( ) ( )		Fax Number ( ) ( )		Initial Treatment Date		
	Street Address				City		State	9-digit ZIP Code		
	Diagnosis(es): Include ICD-9 Code(s)									
	Provider Signature				BWC Provider Number			Date		

<b>Employment Info.</b>	Employer Name				Policy Number		<input type="checkbox"/> Employer is Self-Insuring <input type="checkbox"/> Injured Worker is Owner/Partner/Member of Firm			
	Mailing Address (Number and Street, City or Town, State, and ZIP Code)								County	
	Location, if different from mailing address								Manual Number	
	Telephone Number ( ) ( )		Fax Number ( ) ( )		Federal ID number					
	<input type="checkbox"/> <b>CERTIFICATION</b> - The employer certifies that the facts in this application are correct and valid.				<input type="checkbox"/> <b>REJECTION</b> - The employer rejects the validity of this claim for the following reason(s) below:				<b>FOR SELF-INSURING EMPLOYERS ONLY:</b> <input type="checkbox"/> <b>CLARIFICATION</b> - The employer clarifies and allows the claim for the condition(s) below:	
Employer Signature and Title						Date		OSHA Case Number		

# Completion Instructions

(continued)



Last Name, First Name, Middle Initial			Social Security Number		Marital Status		Date of Birth	
Home Mailing Address			Sex		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Number of Dependents	
City			State		9-digit ZIP Code		Country if different than USA	
Wage Rate			<input type="checkbox"/> Hour <input type="checkbox"/> Month <input type="checkbox"/> Week Per: <input type="checkbox"/> Year <input type="checkbox"/> Other		What days of the week do you usually work? <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thur <input type="checkbox"/> Fri <input type="checkbox"/> Sat		Regular Work Hours	
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?			<input type="checkbox"/> YES <input type="checkbox"/> NO		Occupation or Job Title		From To	
I am applying for recognition of my claim under the Ohio Workers' Compensation Act for work-related injuries that are not primarily inflicted by 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			I am releasing all 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		Work Number	
Benefit Application/Medical Release			Injured Worker Signature		Date			

Injured Worker Info.

- 1 Home Address:** Enter the home address where the injured worker lives. Include the apartment number, if applicable.
  - If the post office does not deliver mail to the home address, list the mailing address instead of the home address.
- 2 Department Name:** Enter the injured worker's department or area name, where he/she normally reports for work.
- 3 Wage Rate:** Enter the injured worker's rate of pay and then select how often it is received. (If the pay rate being reported is not hourly, report the GROSS amount.)
  - If eight or more days of work will be missed, BWC will need wage information for the 52 weeks prior to the date of injury. Submit wage information by: employer payroll reports, wage statement (BWC form C-94-A), W-2s, etc.
- 4 What days of the week do you usually work? / Regular Work Hours:** Enter the days and hours the injured worker normally works.
  - If the days worked vary from week to week, list the number of hours worked in an average week.
- 5 Occupation or Job Title:** Enter the injured worker's type of occupation or actual job title at the time of injury, occupational disease, or death.
- 6 Injured Worker Signature (Injured Workers Only):** Please read the Benefit Application/Medical Release information before signing and dating this form.

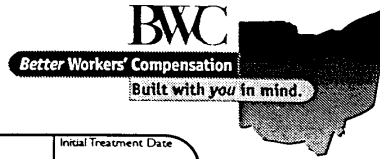
Date of Injury/Disease		Time of Injury		if fatal, give date of death		Date Last Worked		Date Returned to Work	
Accident Location (street address)		<input type="checkbox"/> AM <input type="checkbox"/> PM		Date Hired		State Where Hired		Date Employer Notified	
City		State		Was place of accident or exposure on employer's premises?		<input type="checkbox"/> YES <input type="checkbox"/> NO		Type of Injury/Disease and Part(s) of Body Affected (For example: sprain of lower left back, etc.)	
Description of Accident (Describe the sequence of events that directly injured the employee, or caused the disease or death)									

Injury/Disease/Death Info.

- 1 Date of Injury/Disease:** Enter the date the injured worker was injured.
  - or
  - If the injured worker contracted an occupational disease, determine which of the following happened first:
    - The occupational disease was diagnosed by a medical provider;
    - The first medical treatment; or
    - The injured worker first quit work due to the occupational disease.
 Enter this as the date of occupational disease.
- 2 Date Last Worked:** Enter the last day worked as a result of this injury, occupational disease or death.
- 3 Date Returned to Work:** Enter the date the injured worker returned to work after the injury or occupational disease.
- 4 State Where Hired:** Enter the state where the injured worker was hired by the employer listed on this application.
- 5 Date Employer Notified:** Enter the date the employer was notified of this injury, occupational disease, or death.
- 6 Description of Accident:** Describe in detail the events that caused the injury, occupational disease, or death. Attach additional sheets, if necessary.
- 7 Type of Injury/Disease and Part of Body Affected:** Describe the nature of the injury, occupational disease, or death. Indicate the part(s) of body injured, affected, or that caused the death.
  - For Example: Laceration of first toe, left foot; Sprain of lower right back; etc.

Instructions continued on last page

**Completion Instructions**  
(continued)



<b>Treatment Info.</b>	Physician/Health-Care Provider Name	Telephone Number ( )	Fax Number ( )	Initial Treatment Date
	Street Address	City	State	9-digit ZIP Code
	Diagnosis(es): Include ICD-9 Code(s)			
	Provider Signature	BWC Provider Number ①	Date	

**Treatment Info.**

**① BWC Provider Number:** Enter the physician's or health-care provider's 11-digit, BWC-assigned provider number.

**If you have any questions regarding the BWC provider number, please call 1-800-OHIOBWC (1-800-644-6292), and press 42.**

<b>Employment Info.</b>	Employer Name ①	Policy Number ③	<input type="checkbox"/> Employer is Self-Insuring
	Mailing Address (Number and Street, City or Town, State, and ZIP Code) ②		<input type="checkbox"/> Injured Worker is Owner/Partner/Member of Firm
	Location, if different from mailing address		County
	Telephone Number ( )	Fax Number ( )	Manual Number ④
		Federal ID number	
	<input type="checkbox"/> <b>CERTIFICATION</b> - The employer certifies that the facts in this application are correct and valid. ⑤	<input type="checkbox"/> <b>REJECTION</b> - The employer rejects the validity of this claim for the following reason(s) below: ⑥	<b>FOR SELF-INSURING EMPLOYERS ONLY:</b> <input type="checkbox"/> <b>CLARIFICATION</b> - The employer clarifies and allows the claim for the condition(s) below: ⑦
Employer Signature and Title	Date	OSHA Case Number ⑧	

**Employment Info.**

**① Employer Name:** Enter the name of the injured worker's employer at the time of injury, occupational disease, or death.

**② Mailing Address:** Enter the employer's address where BWC should send all workers' compensation correspondence.

**③ Policy Number:** Enter the employer's BWC-assigned policy number, which is located on the BWC certificate of coverage.

**④ Manual Number:** Enter the four-digit code that indicates the injured worker's job classification, located on the semiannual payroll report.  
• If you do not know the injured worker's manual number, call 1-800-OHIOBWC (1-800-644-6292), and press 21.

**⑤ Certification:** If certification is selected and the claim is allowed, it will be promptly paid. Employers certifying a claim waive both the notice of receipt and notice of first order of compensation.

**⑥ Rejection of a Claim:** If rejection is selected, use the space provided to list the reasons for rejection. Attach additional sheets, if necessary.

**⑦ Clarification of a Claim (Self-Insuring Employers Only):** Self-insuring employers choosing to clarify certification may use the space provided. Attach additional sheets, if necessary.

**⑧ OSHA Case Number:** If this is an OSHA-reportable injury, include the case number assigned by the employer. This form meets OSHA 101 requirements outlined on Jan. 1, 1987, and may be used in lieu of the OSHA 101 when reporting recordable injuries and illnesses to the federal government.

**Note:**  
If your employee misses eight or more days of work, BWC will need wage information for the 52 weeks prior to the date of injury. Submit wage information by: employer payroll reports, wage statement (BWC form C-94-A), W-2s, etc.

**THIS SPACE FOR BWC/MCO USE ONLY**

**DATE MCO RECEIVED CLAIM**

Will this incident cause the injured worker to miss eight or more days of work?—  Yes  No

**DATE BWC RECEIVED CLAIM**

**BWC CLAIM NUMBER**