Ports Petroleum Company, Inc.
Injury and Illness Incident Report

About the Employee

Name_____ Clock No._____ Date of Birth_____

Address_____ City_____ State_____ Zip_____

Phone Number_____ SSN_____ Male or Female_____

Job Title_____ Department_____ Date of Hire_____

About the Incident

Was the incident an injury, illness or a near miss?_____ Date of Incident_____

Time of Incident_____ Time Employee Began Work_____ Date Incident Reported_____

Where did the incident occur?_____ OSHA Case #(for Safety Director)_____

Witness(es)_____

What activity was the employee doing when incident occurred?_____

What happened?_____

_____

Type of Injury or Illness_____ Injured Body Part (Draw circle on next page)_____

What object or substance directly harmed the employee?_____

Was there prior claims/treatment to same body part(s)? _____ Date of Death (if applicable)_____

Root Cause(s) of Incident_____

Corrective Action_____

Physician or Health Care Professional Information

Physician/Health Care Professional Name_____ Facility Name_____

Address_____ City_____ State_____ Zip_____

Was employee treated in an emergency room?_____ Was employee hospitalized overnight as an in-patient?_____

Report Information

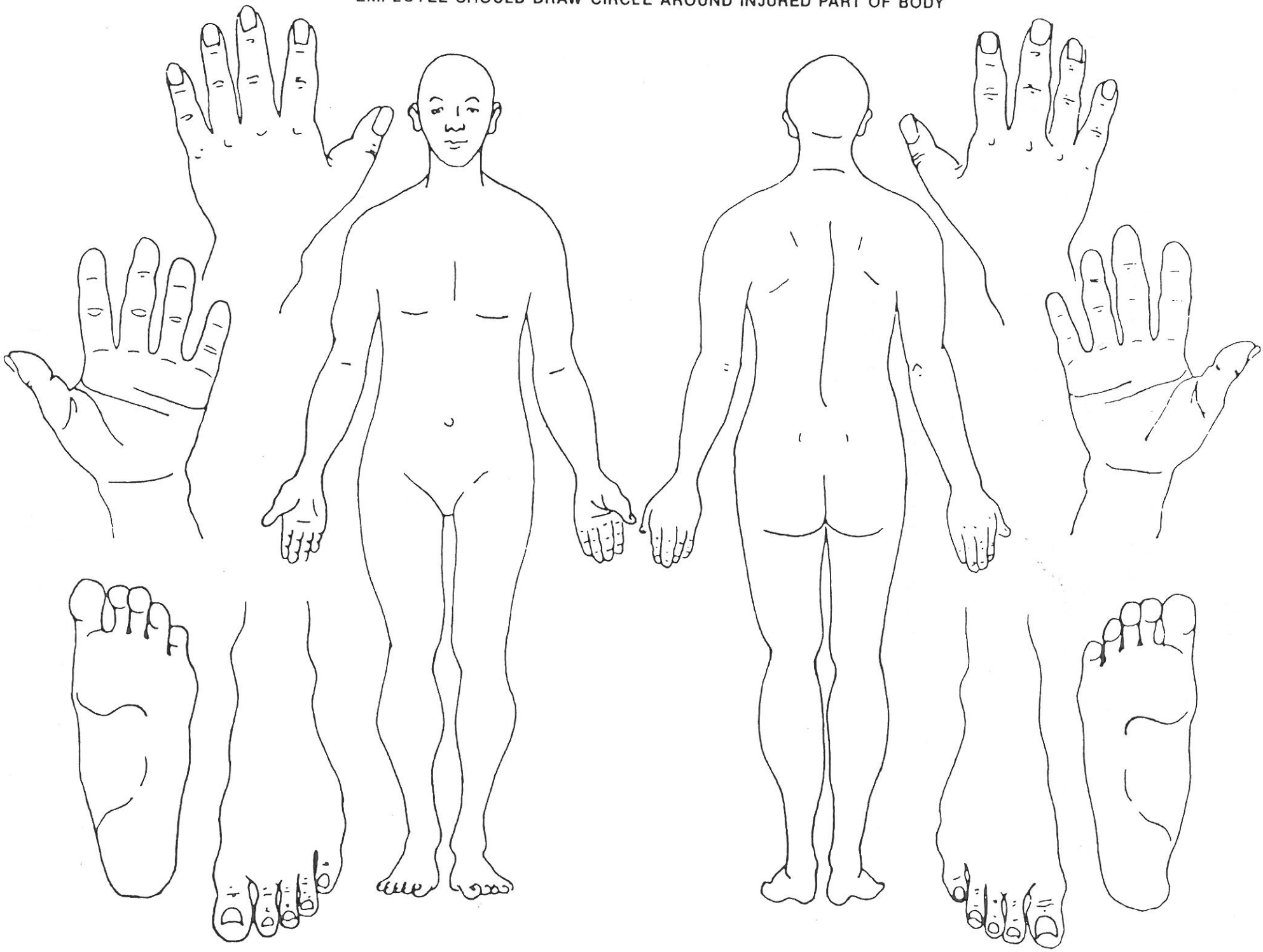
Completed By_____ Title_____ Date_____

As provided by Section 4123.651 (c) of the Ohio Revised Code, I hereby permit the release of medical information, records and reports, relative to the issues necessary for the administration of my Worker's Compensation claim to the Industrial Commission of Ohio, the Ohio Bureau of Worker's Compensation, and the employer as such medical information, records and reports may possibly pertain to a condition either allowed or alleged in my claim, or to consider payment or to determine the eligibility of payment of compensation and medical benefits under my Worker's Compensation claim. A copy shall be as good as the original.

Employee Signature_____ Date Form Completed_____

This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

EMPLOYEE SHOULD DRAW CIRCLE AROUND INJURED PART OF BODY



LEFT FRONT BACK RIGHT

Accident Witness Statement

Ports Petroleum Company, Inc.

1) Name of witness (first & last name):		
2) Primary contact number:		
3) Secondary contact number:		
4) Home address of witness:		
City:	State:	Zip:
5) Witness Employer:		
6) Were you involved in the accident (i.e. driver, passenger, etc.):		
7) Did you witness the accident:		
8) Location of witness (be specific):		
9) Name of individual involved in accident:		
10) Date of accident:		
11) Time of accident:		
12) Location of accident (Address, name of building, mile marker, etc.):		
13) Area of accident (bathroom, parking lot, etc.):		
14) Describe fully how the accident occurred (Including the events that occurred immediately before):		
15) Describe visual bodily injuries sustained (be specific about body part(s) affected):		
16) Name(s) of other witnesses & contact information:		
17) Signature of witness:		
18) Date:		

SMA InsideInfo

Your Information Source for Workers' Compensation

SPOONER MAI
Spooner Medical Administrators, Inc.

I just got injured at work, What do I need to know?

- **The Ohio Bureau of Workers' Compensation is in charge of approving your claim and will send you a letter with their decision about your claim.**
- **You will receive a letter with a medical card from the BWC that can be used for work-related injuries.**
  - If you need to see a doctor because of your injury, then you should show the doctor the card for their file.
- **The doctor that treats you must be certified by the Ohio Bureau of Workers' Compensation.**
  - If needed, we can assist you with finding a doctor.
- **The doctor must get our approval for more treatment after the initial visit.**
- **You are not required to pay the doctor for approved treatment for your allowed workers' compensation claim.**
  - If you receive a bill, call our office.
  - If you have paid for medical services out of your own pocket, then you can apply for reimbursement by sending the bill and proof of payment to our office.
- **The Bureau of Workers' Compensation is in charge of paying for your medication for your work injury.**
- **The Bureau of Workers' Compensation is in charge of calculating payment for lost work time that meets their guidelines.**

Spooner Medical Administrators, Inc. is the company that your employer selected to help with their workers' compensation claims. Our services include case management, prior authorization of medical treatment and payment of medical bills. Contact us with any question you have about your claim or the workers' compensation process.

Spooner Medical Administrators, Incorporated
Phone (440)899-2400 or (800)542-9479
Fax (440)899-2411 or (800)542-9480

www.spoonermai.com

Fee bills should be submitted to:
28301 Ranney Parkway
Westlake, Oh 44145

Ohio | Bureau of Workers' Compensation

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)

Injured worker and injury/disease/death info.

Last name, first name, middle initial | Social Security number | Marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed | Date of birth

Home mailing address | Sex ☐ Male ☐ Female | Number of dependents

City | State | 9-digit ZIP code | Country if different from USA | Department name

Wage rate $ _____ 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 _____ To _____

Have you been offered or do you expect to receive payment or wages for this claim from anyone other than the Ohio Bureau of Workers' Compensation? ☐ Yes ☐ No If yes, please explain. | Occupation or job title

Employer name

Mailing address (number and street, city or town, state, ZIP code and county)

Location, if different from mailing address

Was the place of accident or exposure on employer's premises? ☐ Yes ☐ No
(If no, give accident location, street address, city, state and ZIP code)

Date of injury/disease | Time of injury _____ ☐ a.m. ☐ p.m. | If fatal, give date of death | Time employee began work _____ ☐ a.m. ☐ p.m. | Date last worked | Date returned to work

Date hired | State where hired | Date employer notified | State where supervised

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)

Benefit application release of information – I am applying for a claim under the Ohio Bureau of Workers' Compensation Act for work-related injuries that I did not inflict. I affirm that I elect to receive compensation and benefits under Ohio's workers' compensation laws for my claim, and I waive and release my right to file for and receive compensation and benefits under the laws of any other state for this claim. I request payment for compensation and/or medical benefits as allowable, and authorize direct payment to my medical providers. I permit and authorize any provider who attends, treats or examines me, the Ohio State Board of Pharmacy, the Ohio Department of Job and Family Services and the Ohio Rehabilitation Services Commission to release medical, psychological, psychiatric, pharmaceutical, vocational and social information. I understand this may include personally identifying information that is casually or historically related to my physical or mental injuries relevant to issues necessary for the administration of my claim to BWC, the Industrial Commission of Ohio, the employer in this claim, the employer's managed care organization and any authorized representatives. My previous or future BWC claims may affect decisions made in this claim. Proper administration of the present claim may require BWC to share claims information with the employers of record (or their authorized representatives) and/or my authorized representative for any and all such previous or future claims. The released claims information may include any record maintained in my claim files.

Injured worker signature | Date | E-mail address | Telephone number | Work number ( )

Treatment info.

Health-care provider name | Telephone number ( ) | Fax number ( ) | Initial treatment date

Street address | City | State | 9-digit ZIP code

Diagnosis(es): Include ICD code(s)

Will the incident cause the injured worker to miss eight or more days of work? ☐ Yes ☐ No | Is the injury causally related to the industrial incident? ☐ Yes ☐ No

E code | 11-digit BWC provider number | Date

Health-care provider signature

Employer info.

Employer policy number | Check if ☐ Employer is self-insuring ☐ Injured worker is owner/partner/member of firm

Telephone number ( ) | Fax number ( ) | E-mail address | Federal ID number | Manual number

Was employee treated in an emergency room? ☐ Yes ☐ No | Was employee hospitalized overnight as an inpatient? ☐ Yes ☐ No

If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code

☐ **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 reason(s) listed below:

For self-insuring employers only

☐ **Clarification -** The employer clarifies and allows the claim for the condition(s) below:
☐ **Medical only** ☐ **Lost time**

Employer signature and title | Date | OSHA case number

Ohio | Bureau of Workers' Compensation

Physician's Report of Work Ability

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 appropriately checking Yes or No on each section.

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 physical or health restrictions related to allowed conditions in the claim? Yes ☐ No ☐
If yes, are the restrictions: ☐ Permanent ☐ Temporary ***Proceed to section 3B.***
If no, please check the box to indicate the injured worker is released to work as of the date of this exam. ☐ ***Proceed to section 8.***

3B

If there are restrictions, can the injured worker return to the full duties of his/her job held on the date of injury (former position of employment)? Yes ☐ No ☐
If yes, please check the box to indicate that the injured worker is released to work as of the date of this exam. ☐ ***Proceed to section 8.***
If no, please indicate when the injured worker could not do the job held on the date of injury for this period of restricted duty.
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.**

3C

Please indicate which of the activities listed below the injured worker can perform (even if the response to 3B is No.)
If the injured worker is not released to the former position of employment but may return to available and appropriate work with restrictions, please indicate the possible return to work date:_____.
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, can the injured worker 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	N	O	F	C	Pushing/pulling	N	O	F	C
Activity	N	O	F	C	Activity	N	O	F	C	0 - 10 lbs.	☐	☐	☐	☐	0 to 25 lbs.	☐	☐	☐	☐
Bend	☐	☐	☐	☐	Reach above shoulder	☐	☐	☐	☐	11 - 20 lbs.	☐	☐	☐	☐	26 to 40 lbs.	☐	☐	☐	☐
Squat/kneel	☐	☐	☐	☐	Type/keyboard	☐	☐	☐	☐	21 - 40 lbs.	☐	☐	☐	☐	41 to 60 lbs.	☐	☐	☐	☐
Twist/turn	☐	☐	☐	☐	Work with cold substances	☐	☐	☐	☐	41 - 60 lbs.	☐	☐	☐	☐	61 to 100 lbs.	☐	☐	☐	☐
Climb	☐	☐	☐	☐	Work with hot substances	☐	☐	☐	☐	61 - 100 lbs.	☐	☐	☐	☐	100 + lbs.	☐	☐	☐	☐

How many total hours can the injured worker work: _____ per week _____ per day?
In an eight-hour workday, how many total hours can the injured worker: Sit: ____ hours ☐ Continuously ☐ With break
Walk: ____ hours ☐ Continuously ☐ With break Stand: ____ hours ☐ Continuously ☐ With break
Does the injured worker have any functional restrictions based only on allowed psychological conditions? ☐ Yes ☐ No If Yes, please describe in space provided below. Note: If Yes is indicated please reference the MEDCO-16 as needed.
Additionally, in this space, please provide any additional information addressing the injured worker's capabilities and/or job accommodations which may not be addressed above.

Proceed to section 4.

Injured worker name	Claim number	Date of injury

Disability information (If 3B above is "NO" or dates updated - all 4A fields, including site/location if applicable must be completed) (Updates Yes ☐ No ☐)

4A 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.

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 ☐

4B List all other relevant conditions that impact treatment of the conditions listed above (e.g., co-morbidities or not yet allowed conditions).

Clinical findings: You can reference office notes in lieu of writing clinical findings below. (Updates Yes ☐ No ☐)

5 The injured worker is progressing: ☐ As expected ☐ Better than expected ☐ 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.

Maximum medical improvement (MMI) (Updates Yes ☐ No ☐)

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 ☐ No ☐
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.

Vocational rehabilitation (Updates Yes ☐ No ☐)

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 ☐ No ☐ If no, please explain why and provide your recommendations to help the injured worker return to employment.

Treating physician signature - mandatory

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.

Treating physician's name (please print legibly)		Address, city, state, nine-digit ZIP code	
Treating physician's signature			
BWC provider (Peach) number	Date	Telephone number	Fax number