Ohio | Bureau of Workers' Compensation

Self-Insured Employer/Injured Worker Screening

Statewide Disability Evaluation System

Instructions

- The employer should sign and date the form.
- Incomplete and/or improper completion of this form will result in delay in processing.
- Submit to local customer service office: Attn: SDES nurse.
- Please complete this form for the Statewide Disability Evaluation System. This system is for scheduling examinations of injured workers who have received 90 consecutive days of temporary total disability compensation and monitoring for re-examination as necessary. We use this form to identify the injured worker we will examine.

Injured Worker Information			
1. Injured worker name (last, first, middle initial)	2. Social Security number		3. Claim number
4. Address			
5. City	6. County	7. State	8. Nine-digit ZIP code
9. Telephone number ( )	10. Sex ☐ Male ☐ Female	11. Date of birth	12. Date of injury

Employer Information			
13. Employer name			14. Risk number
15. Address		16. Telephone number ( )	
17. City		18. State	8. Nine-digit ZIP code
20. Employer contact	21. Title		

Injured Worker Representative			
22. Representative		23. Telephone number ( )	
24. Address	25. City	26. State	27. Nine-digit ZIP code
28. Contact			

Employer Representative			
29. Representative		30. Telephone number ( )	
31. Address	32. City	33. State	34. Nine-digit ZIP code
35. Contact			

36. Does the employer wish to waive the 90-day exam for this injured worker? ☐ Yes ☐ No If yes, ☐ for this exam only or ☐ indefinitely

Reason _____

NOTE
Do not complete remainder of form if you waive the examination. Please sign, date and complete Waiver.

Physician's Information			
37. Physician of record	38. Specialty		OBWC Provider number
39. Address			40. Telephone number ( )
41. City		42. State	43. Nine-digit ZIP code
44. Consulting physician	45. Specialty		OBWC Provider number
46. Address			47. Telephone number ( )
48. City		49. State	50. Nine-digit ZIP code

51. Allowed condition	(ICD-9) Codes as available

52. Disallowed or unrelated conditions

53. Length of time on job at date of injury	54. Total time worked for employer	55. Job title at date of injury
_____ years _____months _____wks	_____ years _____months _____weeks	

56. Employer job task summary (may attach job description if available)

57. What are the physical requirements of the job?

58. Is there a job for the injured worker to return to? ☐ Yes ☐ No 59. Are there modified work options available to the injured worker? ☐ Yes ☐ No
Please specify:

60. Description of accident (or copy of C-50)

61. Is the injured worker hospitalized? ☐ Yes ☐ No

62. Are there any pre-existing conditions (co-morbidity factors) which could prolong the recovery period? ☐ Yes ☐ No If yes, explain:

63. Is there any additional information relevant to this claim?

64. Expected length of temporary total disability compensation for _____weeks	65. Injured worker has received temporary total disability compensation for _____ days

66. Please include copies **in duplicate** of the medical information/reports in the claim file, for example: C-1-A; C-50; C-84; results of diagnostic studies (X-rays, lab, nuclear medicine, myelogram, MRI, etc.); operative report; hospital discharge summary; history and physical; admission report; physician notes/reports/summaries; physical therapy notes/treatment plan etc.

67. Are you aware of any additional ordered diagnostic studies or scheduled hospitalizations, which the claim file does not contain?

☐ Yes Specify_____

☐ No

OBWC please return examination report to:

Completed by	Date