Ohio | Bureau of Workers' Compensation

Transitional Work Offer and Acceptance Form

Instructions
Complete this form or an equivalent form for every offer of transitional work made to an employee who returns to work with restrictions with a date of injury during the bonus period. Submit the completed form to your managed care organization (MCO), use the MCO fax number on page two.

Employer information

Name of company	Employer's phone number	Policy number
Name of employee		Claim number
Date of injury	Job title	

Transitional work offer

On _____ your physician of record/treating physician _____
Date Physician name

released you to return to work with restrictions. We offer you the opportunity to participate in our transitional work plan in accordance with the restrictions from your physician beginning _____
Program begin date

☐ Employee acceptance ☐ Employee refusal

Employer acknowledgement

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.

Printed name of employer	Title
Signature of employer X	Date signed

Employee agreement

I agree to participate in transitional work activities within the restrictions indicated by my treating physician. 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.

Printed name of employee	
Signature of employee X	Date signed

Agreement verification

Complete this section only if you cannot obtain the employee signature after they successfully return to work for one of the reasons stated below:

☐ Communication barrier ☐ Refuse to sign ☐ Terminated ☐ Seasonal ☐ Quit ☐ Student/intern

☐ Other _____

Attach employee timesheet/pay stub to verify actual return to work.

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MCO fax numbers to submit medical information		
1-888-OHIOCOMP	216-426-0651	888-644-7339
3-HAB	513-221-2008	800-869-1872
AultComp MCO Inc.	330-830-4900	877-738-0058
CareWorks		888-711-9284
CompManagement Health Systems Inc.		800-334-4229
Comp One	330-259-0095	877-283-0921
CorVel OhioMCO, Inc.		877-677-6756
GENEX Care for Ohio		888-275-9719
Health Management Solutions	614-799-0869	888-303-6294
Occupational Health Link	614-825-1459	888-240-6381
Sheakley UniComp	513-326-8005	888-626-2667
Spooner Medical Administrators, Inc.	440-899-2411	800-542-9480
The Health Plan		877-847-6927
University Hospitals CompCare		800-654-3849
Workstar Health Services		877-474-1440