Ohio | Bureau of Workers' Compensation

Waiver of Appeal Period

Instructions

- Please print or type.
- Complete all applicable portions of this form.
- Submit the form by mailing or faxing the signed and dated copy to the customer service office where the claim is located. You may also complete this form online at ohiobwc.com.

Claim Information			
Injured worker name		Date of injury	Claim number
Address	City	State	Nine-digit ZIP code
Employer name			
Address	City	State	Nine-digit ZIP code

Please read the information below before signing this form.
Ohio workers' compensation law permits parties to a claim to waive, in writing, their right to appeal orders issued by BWC and the Industrial Commission of Ohio (IC). To waive an order's appeal period, the following must be filed in writing.

- For orders that include the allowance of anything other than compensation, the injured worker and employer must submit a signed waiver. If the employer is out of business in Ohio, only the injured worker must submit a waiver.
- For orders that include only the allowance of compensation, the employer must submit a signed waiver. If the employer is out of business no waiver is needed.
- For IC orders, BWC must submit a signed waiver, in addition to the injured worker and/or employer.

The injured worker, the employer or attorneys who represent them can sign waivers. Non-attorneys may sign a waiver at the direction of the party they represent, but cannot sign at their independent discretion. When the required parties agree to waive their appeal rights, the order's appeal period automatically expires.

This request for waiver of appeal applies only to the order specified below, not to all past or future orders affecting the claim. Therefore, waiving your right to appeal an order will not prohibit you from appealing other orders pertaining to the claim.

The undersigned agree to waive the right to appeal the order with the mailing date of _____, which was issued in the above named claim.

Injured worker/Authorized representative	Date
X	
☐ I am a non-attorney representative for the injured worker who is signing at the direction of the injured worker.	

Employer/Authorized representative	Date
X	
☐ I am a non-attorney representative for the employer who is signing at the direction of the employer.	

BWC Administrator/Authorized representative	Date
X	
May only waive appeal rights to IC orders.	

Ohio | Bureau of Workers' Compensation

Application for Handicap Reimbursement

Under the Ohio Revised Code Section 4123.343, BWC uses this application to determine the percentage of compensation to properly charge to, or to refund from, the Statutory Surplus Fund due to an aggravation of one or more of the pre-existing conditions below:

01	Epilepsy	11	Cerebral vascular accident	22	Varicose veins
02	Diabetes	12	Tuberculosis	23	Cardiovascular and pulmonary diseases of a firefighter employed by municipal corporation or township as a regular member of a lawfully constituted fire department
03	Cardiac disease	13	Silicosis		
04	Arthritis	14	Psycho-neurotic disability following treatment in a recognized medical or mental institution		
05	Amputated foot, leg, arm or hand				
06	Loss of sight of one or both eyes or partial loss of uncorrected vision of more than 75 percent bilaterally	15	Hemophilia	24	Coal miners pneumoconiosis
		16	Chronic osteomyelitis	25	Disability with respect to which an individual has completed a rehabilitation program for a previous injury or claim (ORC 4121.61-69)
07	Residual disability from poliomyelitis	17	Ankylosis of joints		
		18	Hyper insulinism		
08	Cerebral palsy	19	Muscular dystrophies		
09	Multiple sclerosis	20	Arterio-sclerosis	26	Service connected injury (see ORC 4123.63)
10	Parkinson's disease	21	Thrombo-phlebitis		

Attachments

1. Medical evidence (in the form of doctor's reports, diagnostic tests such as an MRI, X-RAY, or CTScan, laboratory records) that the employee suffered from one or more of the conditions listed above.
2. Evidence that the condition constituted a handicap within the meaning of the law, including but not limited to evidence that **prior** to the injury, disease or death, the handicap condition caused the employee to be hospitalized or to obtain extensive medical treatment.
3. Evidence that the injury, disease, death, or the handicap condition caused the employee to be absent from work for at least eight or more consecutive days or resulted in a scheduled loss under R.C. 4123.57(B).
4. Evidence in the form of affidavits or medical reports to support the contention that the injury, disease or death would not have occurred but for the pre-existing handicap condition of the employee or that the resulting disability or death was caused, in part, through aggravation of the handicapped condition.
5. Under BWC rules, if the application is not accompanied by all relevant medical evidence and substantial proof, the Administrator may dismiss the application.

Filing instructions

- You may hand deliver this application to:
  BWC, Customer Service, 30 W. Spring St., Columbus, OH, Second Floor.
- You may mail this application to: **BWC, Attn: Handicap Reimbursement Unit, 30 W. Spring St., 26th Floor, Columbus, OH 43215-2256.** If you provide a copy of the application and a self-addressed stamped envelope, BWC will mail a date-stamped copy to the employer representative. Note: You may send an e-mail with any questions concerning the Handicap Reimbursement Program by using: HandreimbQuest@bwc.state.oh.us

To be completed by employer or employer representative

Injured worker name	Social Security number	Claim number

Nature of handicap	Date of injury	Date of death

History of Injury	Allowed condition(s) in this claim

State how the pre-existing handicap increased the cost of this claim (Staple attach all forms) ***Note: The administrator will not consider applications lacking a sufficient description concerning the handicapped condition's impact on the occupational injury, disease or death. The administrator will make a determination based on the information contained in this application.***

Type of compensation	☐ Temporary Total	☐ Wages in lieu of TT *(attach proof)*	☐ R.C. 4123.57 (B) *(scheduled loss)*	☐ Permanent Total	☐ Death
Do you request an informal conference	☐ In person	☐ By phone	Contact name		

Fill out information below completely

Employer name	Risk number	Manual number

Address	Telephone number ( )

City	State	Nine-digit ZIP code	E-mail address

Employer representative name	Docketing (contact name)

Address	Telephone number ( )

City	State	Nine-digit ZIP code	E-mail address