



**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. Fax 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

☐ Despite a release to work with restrictions you can work in your job of injury without accommodations.

**Employer acknowledgement 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 to participate in transitional work activities**      ☐ **Employee refusal to participate**

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.



**Instructions**

Fax this form to the appropriate MCO listed below.

**MCO fax numbers to submit medical information**

<b>1-888-OHIOCOMP</b>	216-426-0651	888-644-7339
<b>3-HAB</b>	513-221-2008	800-869-1872
<b>AultComp MCO Inc.</b>	330-830-4900	877-738-0058
<b>CareWorks</b>		888-711-9284
<b>CompManagement Health Systems Inc.</b>		800-334-4229
<b>Comp One</b>	330-259-0095	877-283-0921
<b>CorVel OhioMCO, Inc.</b>		877-677-6756
<b>GENEX Care for Ohio</b>		888-275-9719
<b>Health Management Solutions</b>	614-799-0869	888-303-6294
<b>Occupational Health Link</b>	614-825-1459	888-240-6381
<b>Sheakley UniComp</b>	513-326-8005	888-626-2667
<b>Spooner Medical Administrators, Inc.</b>	440-899-2411	800-542-9480