Bureau of Workers' Compensation

Transitional Work Offer and Acceptance Form

Instructions
Required for Transitional Work Bonus periods: January 2022, July 2022, and January 2023
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.

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 below.

Managed care organization	Phone number	Fax number	Email address
Minute Men OhioComp	216-426-0651	888-644-7339	10041-1-888-ohiocomp@exchange.state.oh.us
3-HAB	800-869-1871 x3206	513-985-1381	info@3hab.com
Ault Comp MCO Inc.	330-830-4900	877-738-0058	aultcompmco@aultcompmco.com
Sedgwick MCO		888-627-0074	Injury.incident@sedgwickmco.com
CorVel Ohio MCO, Inc.		877-677-6756	
GENEX Care for Ohio		888-275-9719	genexcareforohio@genexservices.com
ProMedica Medical Management	614-799-0869	888-303-6294	
Occupational Health Link	614-825-1459	888-240-6381	
Sheakley UniComp	513-618-1249	888-626-2667	mco@sheakley.com
Spooner Medical Administrators, Inc.	440-899-2411	800-542-9480	clientservices@spoonermai.com