Bureau of Workers' Compensation

Employer Authorized Representative (R-1)

The employer must complete this form in its entirety and fax it to 1-614-621-3437.
The form is available online at bwc.ohio.gov.

Claimant information		
Claimant name	Date of injury	Claim number

Employer information			
Employer name		Employer policy number	
Address			
City	State	ZIP code	
Email address, if available		Phone number	

Representative information			
*Your representative **must** have a BWC representative identification number prior to being designated as an authorized representative.			
Representative/Firm name			
Representative BWC ID number*		Phone number	
Representative street address			
City	State	ZIP code	
Email address, if available			

Authorization	
I hereby authorize the above representative to represent me in the above claim before the Ohio Bureau of Workers' Compensation and the Ohio Industrial Commission of Ohio. This authorization also entitles this representative to automatically receive correspondence generated in the above claim file.	
Signature of employer official granting this authorization	Printed name
	Date of authorization