Bureau of Workers' Compensation

Claimant Authorized Representative (R-2)

Complete this form in its entirety and fax it to 1-614-621-3437, file the form at the Representative Desk in the William Green building, or send it to the BWC customer service office where your claim is assigned.

The form is available online at bwc.ohio.gov.

Claimant information

Claimant name	Date of injury	Claim number

Claimant address		

City	State	ZIP code

Email address, if available	Phone number

Representative information

*You may have only one legal representative (one attorney or one law firm) and one union representative.
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 authorize the above to be my authorized representative. The authorization entitles the representative access to my complete claim file, including medical and/or other information contained therein, and to receive correspondence generated in the above claim.

I further understand that:

- If I designate an attorney or law firm, BWC will remove any previously designated attorney or law firm as legal authorized representative, and it is my responsibility to notify the former legal representatives of the change;
- If I have previously authorized an individual in this claim to receive my workers' compensation check, **I understand that, if desired, I must cancel the previous authorization separately in writing.**

The authorization above is being given to a:

☐ Attorney ☐ Law firm ☐ Union representative ☐ Other (Please explain.)

Signature of claimant	Printed name
	Date of authorization