



You must complete all fields on this form except for the injured worker email address.

Complete this form, and fax it to 1-866-336-8352, or send it to the BWC customer service office where your claim is assigned. The form is available online at [www.bwc.ohio.gov](http://www.bwc.ohio.gov).

Injured worker information		
Injured worker name	Date of injury	Claim number
Injured worker address		
City	State	ZIP code
Email address, if available	Phone number	
Employer name on the date of injury		

Representative information		
*You may have only one legal representative (one attorney or one law firm) and one union representative. **Your representative <b>must</b> 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

Authorization	
<p><b>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.</b></p> <p><b>I further understand that:</b></p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• If I have previously authorized an individual in this claim to receive my workers' compensation check, <b>I understand that, if desired, I must cancel the previous authorization separately in writing.</b></li> </ul> <p>The authorization above is being given to a:          Attorney <input type="checkbox"/> Law firm <input type="checkbox"/> Union representative <input type="checkbox"/> Other(please explain) <input type="checkbox"/></p>	
Signature of injured worker	Printed name
	Date of authorization