

APPLICATION FOR ADDITIONAL AWARD FOR VIOLATION OF SPECIFIC SAFETY REQUIREMENT IN A WORKERS' COMPENSATION CLAIM

The applicant hereby makes application for an additional award because of failure of the employer to comply with a specific requirement for the protection of the lives, health, and safety of employees.

Address on application is new

Injured Worker Information		Employer Information	
Name		Name	
Address		Address	
City, State, Zip		City, State, Zip	
Telephone	Fax	Telephone	Fax
Injured Worker's Representative Information		Employer's Representative Information	
Rep ID#		Rep ID#	
Name		Name	
Telephone	Fax	Telephone	Fax

The Injured Worker was injured on _____ while employed by _____ .
(mm/dd/yyyy) (Employer's Name)

The Injury was Fatal Non-Fatal.

When the injury occurred, was the Injured Worker employed by a temporary service agency, professional employer organization or staff leasing company? Yes No

If "yes," provide the employer information where the work was being performed:

<small>(Employer Name)</small>	<small>(Address)</small>	<small>(City, State, Zip Code)</small>

Describe, in detail, how the injury occurred (attach extra sheets if necessary): _____

State the specific Ohio Administrative Code Section(s) which were violated, causing the Injured Worker to sustain an injury (attach extra sheets if necessary): _____

Provide the information of the persons who witnessed the accident (if available).

IMPORTANT: The Safety Violations Investigation Unit may be unable to contact your witnesses if the information is not given.

Witness Name	Phone	Address	City, State, Zip Code

Applicant Name Date

Signature