IC-8/9 Ohio Industrial Commission

Application for Additional Award for Violation of Specific Safety Requirement in a Workers' Compensation Claim

(☐ For Fatal or ☐ Non-Fatal Injuries)

Mail this form to:
Industrial Commission of Ohio
VSSR Claims Examiner
30 W. Spring St. 7th floor
Columbus, Ohio 43215 Fax: (614) 995-0696

☐ **APPLICANT'S ADDRESS IS NEW**

CLAIM NUMBER _____

SOCIAL SECURITY # _____

DATE OF INJURY _____

Applicant's Address		Employer's Address	
Name		Name	
Address		Address	
City, State, Zip Code		City, State, Zip Code	
County	Phone ( )	County	Phone ( )
Applicant's Representative		**Employer's Representative**	
Name		Name	

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.

1. **The injured worker was injured on** _____ **at** _____ **M.**
(Month) (Day) (Year)

2. **While employed by:** _____

of _____
(Street Address) (City) (State) (Zip Code) (County)

3. **If the injured worker was employed by a temporary service agency, professional employer organization or staff leasing company at the time of the injury, list the name and address of the employer where the work was being performed.**

_____
(Name)

_____
(Street Address) (City) (State) (Zip Code) (County)

4. **Describe, in detail, how the injury occured (attach extra sheet if necessary).**

_____

_____

_____

5. **Please state the specific Ohio Administrative Code Section (s) which were violated and which caused the injured worker to sustain an injury:(Attach extra sheet if necessary).**

_____

_____

_____

6. **IMPORTANT: Please provide the complete names, addresses, and phone numbers (if available) of persons who witnessed the accident. The Safety Violations Investigation Unit may be unable to contact your witnesses if this information is not given.**

_____

_____

(Please attach any additional informaton)

_____
(Applicant will sign here)