Ohio | **Bureau of Workers' Compensation**

Motion

Instructions

- Parties to the claim requesting a decision by BWC or the Industrial Commission of Ohio must use this form if any other form or application does not apply. Parties to the claim include the injured worker, employer and/or their authorized representatives and BWC. For a complete list of injured worker and employer forms visit **www.bwc.ohio.gov,** or call BWC at **1-800-644-6292.**
- **Health-care providers or managed care organizations (MCOs) do not use this form**. Health-care providers or MCOs must use the *Physician's Request for Medical Service or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease* (C-9).
- You must submit proof with this form to support the requested action. When requesting an additional condition, please include medical documentation, such as medical reports that include a physician statement addressing causal relationship between the requested condition and the industrial injury, diagnostic test results, radiology exam results, operative reports, etc. When requesting full or average weekly wage adjustments, include earning statements, such as pay stubs, C-94A wage statement form, payroll report, W2, tax forms, etc.
- The applicant must mail a copy of the *Motion* to all parties and/or their authorized representatives to the claim and will indicate a copy has been mailed by signing Certificate of Service below.

Section I

Injured worker name		Claim number	
Street address	City	State	Nine-digit ZIP code

This *Motion* is a request to consider the following:

Section II

In support of this *Motion,* the following evidence is included: (Please indicate the evidence included to support the request, such as medical reports that include a physician statement addressing causal relationship between the requested condition and the industrial injury, earning statements or any other evidence to support the requested action as outlined in the instructions.)

Section III

Certificate of Service: I certify I have served a copy of this *Motion* on all parties and representatives to the claim.

Signed _____ Date signed ***12 31 2015***

☐ Injured worker ☐ Employer ☐ Authorized representative ☐ Administrator of the Ohio Bureau of Workers' Compensation