Ohio | Industrial Commission

Claim Number:

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 _____ (mm/dd/yyyy) while employed by _____ (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:

(Employer Name)	(Address)	(City, State, Zip Code)

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