



## 2015 Franklin County Injury Packet

Includes:

- 1) Injury flow chart
- 2) Self-Insured Injury Report form [SI\_ARFIE]
- 3) Medical Release of Information Authorization and list of treating provider forms
- 4) Workers' Compensation & Injury Identification Information
- 5) First Fill Pharmacy Card for acquiring prescription medicines for your injury only.
- 6) Risk Management Contact Information for answering your injury-related questions
- 7) BWC form MEDCO-14 to give to the injured employee's medical provider
- 8) Geographical listing of Ohio BWC certified providers in Central Ohio

***If you are injured at work, you must:***

Report a **new injury** no matter how minor it may seem to your immediate supervisor or agency management **within 24-48 hours in writing by completing a Self-Insured Injury Report form.**

If you choose to file a workers' compensation claim, you must:

Ask your supervisor or Benefits Department for an injury packet or download the Injury Packet from the Franklin County Risk Management website [<http://bewell.franklincountyohio.gov/>]. Complete a **Self-Insured County accident report form for injured employees [SI-ARFIE]** along with the Authorization to Release Medical Information form and list of treating providers and give it to your immediate supervisor.

The packet contains your workers' compensation billing information. Please take this with you to all medical appointments for this injury.

**Attention Supervisors: In case of severely disabling [life or death] traumatic injuries such as a catastrophic motor vehicle accident or other injuries requiring immediate hospitalization or where the injured employee is incapacitated, the injured employee's supervisor shall complete an SI-ARFIE on behalf of the injured employee and process it as directed immediately below.**

**Note to all Injured Employees:** If you seek medical treatment for your injury, please ask your medical provider to complete a BWC MEDCO-14 form. This form must be on file at the time you return to work. Please see the MEDCO-14 in the injury packet.

**In order to process an injury claim, your injury report must be on file within seven days of the date of injury.**

**Supervisor** must complete the Supervisor Section on page 3 of the form and email the completed three-page form to:

Jerry Bower, Risk Manager  
[jabower@franklincountyohio.gov](mailto:jabower@franklincountyohio.gov)  
614-525-4642  
Or fax to: 614-525-5715

Jenell Williams, Business Service Officer  
[jdwillia@franklincountyohio.gov](mailto:jdwillia@franklincountyohio.gov)

**After the supervisor emails or faxes the SI-ARFIE to Risk Management, please make a follow up phone call or leave a voice mail at 614-525-4642 to report the injury.**

373 South High Street, 25th Floor, Columbus, Ohio 43215-4543  
Tel: 614-525-5750 Fax: 614-525-5515 [www.FranklinCountyOhio.gov](http://www.FranklinCountyOhio.gov)

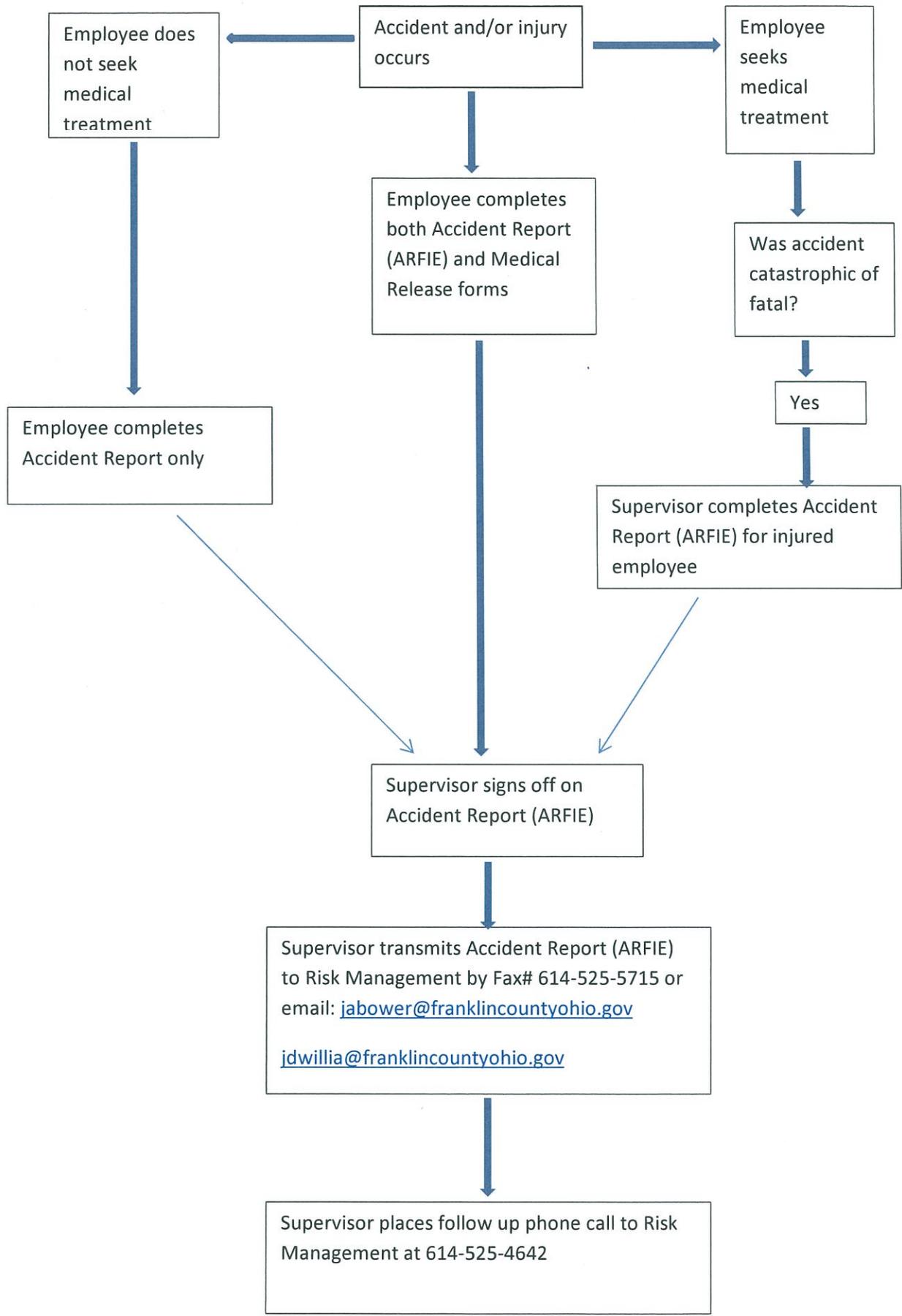


# 2015 INJURY PACKET

This packet contains the following information:

1. Injury Reporting Process Flow Chart
2. Self-Insured Accident Report Form for Injured Employees [SI-ARFIE]\*
3. Medical Release of Information form and list of all treating providers\*
4. Workers' Compensation & Injury Identification Information for all Injuries after
5. April 1, 2012
6. First Fill Temporary Pharmacy Card
7. Business Service Officer Information
8. BWC MEDCO-14 form-sample with instructions for your medical provider
9. Listings of Occupational Medical Treatment Facilities, Urgent Cares & Hospitals

**\*Return/send these completed forms to the Risk Management Department after an injury**





**FRANKLIN COUNTY RISK MANAGEMENT**  
**SELF-INSURED ACCIDENT REPORT FORM for INJURED EMPLOYEES (ARFIE-SI)**  
**for WORKERS' COMPENSATION claims occurring after 4-1-2012 rev. 1-2013**

<b>AGENCY:</b>	<b>FRANKLIN COUNTY SI RISK NO.</b> 20005728	<b>(Risk Mgt. USE ONLY)</b>
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**EMPLOYEE'S INFORMATION:**

<b>EMPLOYEE NAME:</b>	<b>EMPLOYEE S.S. NO:</b>	<b>DEPARTMENT:</b>	
<b>HOME ADDRESS:</b>	<b>HOME or Cell PHONE:</b>	<b>AGE:</b>	<b>BIRTH DATE</b>
<b>CITY, COUNTY, STATE, ZIP CODE</b>	<b>WORK PHONE:</b>	<b>JOB TITLE:</b>	

**ACCIDENT INFORMATION To Be COMPLETED BY SUPERVISOR AND/OR INJURED EMPLOYEE**

<b>SPECIFIC LOCATION OF ACCIDENT OR INJURY:</b>	<b>DATE of INJURY:</b>	<b>INJURY TIME:</b> AM PM
<b>WAS INJURY ON COUNTY PROPERTY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>DATE REPORTED:</b>	<b>WORK SHIFT:</b>
<b>JOB DUTIES BEING PERFORMED AT TIME OF INJURY:</b>	<b>SUPERVISOR'S NAME</b>	
<b>DID INJURED EMPLOYEE RETURN TO WORK?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Date: _____	<b>DID EMPLOYEE GO FOR MEDICAL TREATMENT?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>SUPERVISOR'S PHONE NO.</b>
<b>DESCRIBE ACCIDENT: In your own words, explain in detail how accident occurred [Use additional blank pages if necessary]:</b>		

**INJURED BODY PART (S) (example: left arm, right index finger, upper left thigh)**

- 1 \_\_\_\_\_ 4 \_\_\_\_\_
- 2 \_\_\_\_\_ 5 \_\_\_\_\_
- 3 \_\_\_\_\_ 6 \_\_\_\_\_

**I certify by my signature that the information on this injury report is true and complete to the best of my knowledge.**

<b>Employee Signature</b>	<b>Date</b>
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This is my description of the accident. As provided by Section 4123.651-c of the Ohio Revised Code, I hereby permit the release of all relevant medical information, records and reports, relative to the issues necessary for the administration of my workers' compensation claim to the Industrial Commission, the Ohio Bureau of Workers' Compensation, the employer and its authorized representatives.

<b>Employee Signature</b>	<b>Date</b>
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**Employee must sign two times-one signature to describe occurrence and one to authorize release of medical records.**

Fax to 614-525-5715 or email to [jabower@franklincountyohio.gov](mailto:jabower@franklincountyohio.gov) then call 614-525-4642 to Report New Injury

**ACCIDENT INFORMATION COMPLETED BY INJURED WORKER AND/OR SUPERVISOR**

1. Did employee seek medical attention for the injuries sustained? Yes  No

If yes, list the doctor and/or the medical provider:

Doctor or Medical Provider :		Telephone:	
Address	City:	State:	Zip Code:

Is this doctor/medical provider your family physician? Yes  No

2. Did any other employee or person witness the accident or injury? Yes  No

If yes, list their names below:

a. \_\_\_\_\_ c. \_\_\_\_\_  
 b. \_\_\_\_\_ d. \_\_\_\_\_

3. Was more than one person injured in this accident? Yes  No

If yes, provide their names:

a. \_\_\_\_\_ c. \_\_\_\_\_  
 b. \_\_\_\_\_ d. \_\_\_\_\_

4. Was any work place machinery or equipment involved? Yes  No

5. If your answer is "yes". Please provide the following information:

TYPE OF EQUIPMENT:	MANUFACTURER:	EQUIPMENT'S AGE:	MODEL NO.:
HAS MACHINE BEEN MODIFIED? YES <input type="checkbox"/> NO <input type="checkbox"/>	HOW?	WHY?	

6. Was there mechanical failure? Yes  No

7. If "yes", please describe:

8. Was the injury caused by any outside contractor or repair company(s)? Yes  No

9. If yes, please answer the following:

Name of Firm                      Its address                      City, State, Zip                      Contact Person                      Telephone No.

10. Was this injury the result of an automobile accident? Yes  No

11. If you answered yes to Question 10, were you cited for any moving violation(s)? Yes  No

If yes, list the violation(s)

If you answered yes to Question 10, you are required to provide a copy of the local police auto accident report.

Fax to 614-525-5715 or email to [jabower@franklincountyohio.gov](mailto:jabower@franklincountyohio.gov) then call 614-525-4642 to Report New Injury

12. Was the injury a result of lifting or handling objects? Yes  No
13. If you answered yes to question 12, what was the approximate weight of the object handled? \_\_\_\_\_ pounds
14. Did anyone help you lift the object? Yes  No
- If yes, who? \_\_\_\_\_

**Supervisor's Section-Please complete the following for accident analysis purposes**

ENVIRONMENTAL CONDITIONS (if applicable):  _____  SURFACE: _____ LIGHT: _____  ANY OTHER ENVIRONMENTAL FACTORS:  _____		WORKING OVERTIME? Yes <input type="checkbox"/> No <input type="checkbox"/>	AUTO ACCIDENT Yes <input type="checkbox"/> No <input type="checkbox"/>
		ON COUNTY'S PREMISES? Yes <input type="checkbox"/> No <input type="checkbox"/>	IF "YES", ATTACH POLICE REPORT
		DID EMPLOYEE RETURN TO WORK? Yes <input type="checkbox"/> No <input type="checkbox"/>	COUNTY OWNED VEHICLE? Yes <input type="checkbox"/> No <input type="checkbox"/>
		IF YES, WHEN? _____	HAS INJURED PERSON TAKEN THE SHERIFF'S DEFENSIVE DRIVING COURSE? Yes <input type="checkbox"/> No <input type="checkbox"/>
Reported By:	Date and Time:	Phone <input type="checkbox"/> Fax <input type="checkbox"/> Email <input type="checkbox"/>	

I have reviewed this accident report and am aware of the details of the accident. (You may comment on or dispute any or all of the injured employee's statements or accident description below or on separate paper.) Please provide ANY relevant information below. Use additional pages if necessary. Fax the completed form to 614-525-5715 or email these pages to [jabower@franklincountyohio.gov](mailto:jabower@franklincountyohio.gov) then call 614-525-4642 [24/7/365] to advise Risk Management of the new injury. You may hear a recording so please leave a voice message.

SUPERVISOR'S NAME & SIGNATURE:	DATE:
WORK EMAIL ADDRESS:	YOUR WORK PHONE OR WORK CELL PHONE

Fax to 614-525-5715 or email to [jabower@franklincountyohio.gov](mailto:jabower@franklincountyohio.gov) then call 614-525-4642 to Report New Injury



Instructions

- Please print or type.
List the provider(s) you are authorizing to release medical records in the space indicated on this form.
Please sign and date the form, and send it to the customer service office where your claim is located or to your self-insured employer.

You can obtain this form online at ohioBWC.com

Form with fields: Injured worker name (first, M.I., last), Date of injury, Claim number, Address, City, State, Nine-digit ZIP code, Employer name (Franklin County Commissioners), Self-Insured Employer 20005728

I, the above-named injured worker, understand I am allowing the Ohio Rehabilitation Services Commission and the providers (persons or facilities) named here (

that attend or examine me to release the following medical, psychological and/or psychiatric information (excluding psychotherapy notes) that are related causally or historically to physical or mental injuries relevant to my workers' compensation claim:

- Pathology slides and immunohistochemical staining results, if applicable;
Hospital admission history and physical; emergency room reports; hospital discharge summaries; physician office notes; physical therapist, occupational therapist or athletic trainer assessments and progress notes; consultation reports; lab results; medical reports; surgical reports; diagnostic reports; procedure reports; nursing home and skilled nursing facilities documentation; home nursing progress notes; or other listed below.

I understand I am authorizing the release of this information to the following: the Ohio Bureau of Workers' Compensation (BWC), the Industrial Commission of Ohio, the above-named employer, the employer's managed care organization or qualified health plan and any authorized representatives.

I understand this information is being released to the above-referenced persons and/or entities for use in administering my workers' compensation claim.

This authorization to release medical, psychological and/or psychiatric information shall remain in effect for as long as my workers' compensation claim remains open under Ohio law. I understand I have the right to revoke this authorization at any time. However, I must submit my revocation in writing and file it with BWC or my self-insured employer. My decision to revoke this authorization will be effective, except in the case that any provider referenced above already has relied on my authorization and released information.

I understand the provider(s) referenced above may not make my completing and signing this authorization a condition of my treatment.

I understand the parties I am authorizing the release of information to are exempted from the federal privacy requirements of the Health Insurance Portability and Accountability Act of 1996 as they administer workers' compensation programs. Information disclosed pursuant to this authorization may be redisclosed by them and may no longer be protected by the federal privacy requirements. I understand such redisclosures may include but are not limited to the following:

- A copy of the medical information the employer receives may be forwarded to BWC by the employer;
A copy of the medical information will be available to me or my physician of record upon request to BWC or to the employer.

Form with fields: Injured worker (or guardian or personal representative) signature, Date

If signed by the injured worker's guardian or personal representative, provide a description of the guardian or personal representative's authority to sign on behalf of the injured worker.

Claimant :  
Claim No. :  
Employer : Franklin County Commissioners

**List of Medical Treatment and Providers**

(1) Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Telephone \_\_\_\_\_  
\_\_\_\_\_

(2) Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Telephone \_\_\_\_\_  
\_\_\_\_\_

(3) Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Telephone \_\_\_\_\_  
\_\_\_\_\_

(4) Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Telephone \_\_\_\_\_  
\_\_\_\_\_

(5) Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Telephone \_\_\_\_\_  
\_\_\_\_\_

(6) Name \_\_\_\_\_

Claimant :  
Claim No. :  
Employer : Franklin County Commissioners

**List of Medical Treatment and Providers**

Address

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Telephone

---

(7) Name

---

Address

---

---

---

Telephone

---

(8) Name

---

Address

---

---

---

Telephone

---

(9) Name

---

Address

---

---

---

Telephone

---

(10) Name

---

Address

---

---

---

Telephone

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**WORKERS' COMPENSATION & INJURY  
IDENTIFICATION INFORMATION**

**EFFECTIVE: APRIL 1, 2012**

**THIS FORM IS FOR THE  
INJURED EMPLOYEE**

**Employer Risk Number is 20005728-0.**

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**Note: Please provide the information listed  
below to each medical provider that treats you  
for your injury.**

**Attention Provider:**

**FAX all information within 24 hours of visit to:**

**Sedgwick 614-658-0901**

**Send bills to:**

CompManagement-SedgwickCMS

P.O. Box 14661

Lexington, KY 40512-4661

This page does not guarantee claim approval.

1(800) 267-4001 Customer Service, ask for a claims adjuster.

**1(614) 658-0901 Fax**

***Franklin County is a self-insured employer.***

**EFFECTIVE: APRIL 1, 2012**

## MAKING IT EASY... TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Helios has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

### Injured Employee:



If you need a prescription filled for a work-related injury or illness, go to a Helios Tmesys network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.



If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.



Most pharmacies, including Walgreens, our preferred provider, and all major chains, are included in the network. To find a network pharmacy call 866.599.5426 or visit [www.tmesys.com](http://www.tmesys.com) and click on "Pharmacy Locator."

### Questions? Need Help?



**866.599.5426**

<b>tmesys</b> sedgwick	
Sedgwick CARRIER/TPA	Franklin County Board of Commissioners EMPLOYER
INJURED WORKER NAME	
Please provide directly to Pharmacist	
SOCIAL SECURITY NUMBER	DATE OF INJURY (YYMMDD)
<b>Notice to Cardholder:</b> Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: <a href="http://www.tmesys.com/pharmacy-locator">www.tmesys.com/pharmacy-locator</a>	

**Attention Pharmacists:** Call 800.964.2531 to establish First Fill benefit eligibility and obtain the ID number for online adjudication of approved benefits for the injured worker. Tmesys is the designated PBM for this patient.

### Tmesys Pharmacy Help Desk 800.964.2531

	<u>NDC</u>		<u>Envoy</u>
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #

*NOTE: This First Fill card is only valid for your workers' compensation injury or illness.*



### Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

Jenell D. Williams is the Business Service Officer in the Franklin County Office of Benefits and Risk Management.

How can the Business Service Officer assist employees?

Ms. Williams's Role is to serve as the liaison between you and our Self Insured Third Party administrator. If you are hurt on the job, she is available to help you through the Workers' Compensation Process and assist you in returning to work as soon as medically possible. Any time assistance is needed associated with required paperwork or you have any questions regarding your claim your Business Service Officer will be ready to assist you.

If you ever have a question or concern regarding your claim please feel free to contact her.

614-525-6629 Phone

614-525-5515 Fax

[jdwillia@franklincountyohio.gov](mailto:jdwillia@franklincountyohio.gov) Email



Injured worker name	Claim number	Date of injury
Employer name and injured worker's position of employment at time of injury	Date of last exam or treatment	Next appointment date

**Injured worker progress**

1 The injured worker is progressing:  As expected  Better than expected  Slower than expected  
 If a MEDCO-14 was previously completed for this injured worker, are there any changes to the information provided in Section 2 through 7 to report at this time?  Yes  No *If yes, proceed to section 2. If no, proceed to section 8.*

**Work status**

Did you review a description of the injured worker's job duties as they existed on the date of injury (former position of employment)? Check all applicable boxes.  
 Yes, I was provided a job description (verbal or written) by the  Injured worker  Employer  MCO  
 No, I have not been provided a job description.  
**Select one of the three options below.**  
 2  Injured worker is temporarily not released to any work, including the former position of employment from (date): \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_. *Please complete required sections 4, 5, 6, 7 and 8.*  
 Injured worker is not released to the former position of employment but may return to available and appropriate work with restrictions, from (date): \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_. *Please complete required sections 3, 4, 5, 6, 7 and 8.*  
 The restrictions are:  Permanent  Temporary If temporary until what date? \_\_\_/\_\_\_/\_\_\_  
 Injured worker is released to the former position of employment without restrictions as of (date): \_\_\_/\_\_\_/\_\_\_.  
 Is this date the day the injured worker actually returned to work?  Yes  No  I don't know. *Proceed to section 8 and complete it.*

**Injured worker's capabilities: Employer will use information in this section to evaluate available and appropriate work opportunities**

How many total hours is this injured worker potentially able to work? \_\_\_\_\_ Hours in a day \_\_\_\_\_ Hours in a week

**Upper extremities**  
 The injured worker is able to perform simple grasping with:  Left hand  Right hand  Both  
 The injured worker is able to perform repetitive wrist motion with:  Left hand  Right hand  Both  
 The injured worker's dominant hand is:  Left  Right

**Lower extremities**  
 The injured worker is able to perform repetitive actions to operate foot controls or motor vehicles with:  Left foot  Right foot  Both

**Medications**  
 The injured worker is able to safely perform work duties which, if applicable, may include operating heavy machinery or driving while taking prescribed medications:  Yes  No  
 If no, what are the potential side effects:  Dizziness  Drowsiness  Impaired ability  Other, please explain

Please indicate the following: N = Never, O = Occasionally, F = Frequently, C = Continuously

Lifting/carrying					Pushing/pulling					Activity					Activity				
	N	O	F	C		N	O	F	C		N	O	F	C		N	O	F	C
0 - 10 lbs.					13 to 25 lbs.					Bend					Reach above shoulder				
11 - 20 lbs.					26 to 40 lbs.					Squat					Type/keyboard				
21 - 40 lbs.					41 to 60 lbs.					Kneel					Driving				
41 - 60 lbs.					61 to 100 lbs.					Twist/turn					Automatic				
61 - 100 lbs.					100 + lbs.					Climb					Standard shift				

**In an eight-hour workday, how many total hours is the injured worker potentially able to work?**  
 Sit: \_\_\_ hours  Continuously  With break    Walk: \_\_\_ hours  Continuously  With break    Stand: \_\_\_ hours  Continuously  With break

**Degree of functional impairment based on allowed psychological conditions only, if applicable.**

	None	Mild	Moderate	Marked	Extreme
<b>Activities of daily living:</b> Self-care, personal hygiene, communication, ambulation, travel, sexual function, sleep, social and recreational activities and occupational functioning	<input type="checkbox"/>				
<b>Social functioning:</b> Capacity to interact and communicate effectively and get along with others	<input type="checkbox"/>				
<b>Concentration, persistence and pace:</b> Ability to sustain focused attention long enough to complete tasks commonly found in the workplace	<input type="checkbox"/>				
<b>Adaptation:</b> Ability to appropriately react to stressful circumstances, including the workplace; includes attendance, making decisions, scheduling or completing tasks and interacting with supervisors and co-workers	<input type="checkbox"/>				

Injured worker name	Claim number	Date of injury
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**Disability period information (all fields required, including site/location if applicable)**

Complete the chart below and furnish the narrative description of the diagnosis(es), site/location, if applicable, and ICD code for the conditions being treated due to the work-related injury. Please indicate if the condition is causing temporary total disability (all fields required, including site/location, if applicable).

4	Narrative description of the work-related condition	Site/Location If applicable	ICD code	Is the condition causing temporary total disability?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

List all other conditions being treated (attach additional sheet if necessary).

**Clinical findings**

5 Provide your clinical and objective findings supporting your medical opinion outlined on this form. List any barriers to return to work and any reason for the injured worker's delay in recovery.

**Maximum medical improvement (MMI)**

6 MMI is a treatment plateau (static or well-stabilized) at which no fundamental functional or physiological change can be expected within reasonable medical probability in spite of continuing medical or rehabilitative procedures. An injured worker may need supportive treatment to maintain this level of function. Note: periodic medical treatment may still be requested and provided. Has the work-related injury(s) or occupational disease reached MMI based on the definition above?  Yes  No

If yes, give MMI date: \_\_\_\_/\_\_\_\_/\_\_\_\_. If no, please provide the proposed treatment plan, including estimated duration of each treatment (attach additional sheet if necessary).

**Vocational rehabilitation**

7 Vocational rehabilitation is an individualized and voluntary program for an eligible injured worker who needs assistance in safely returning to work or in retaining employment. This program can be tailored around an injured worker's restrictions, and may provide job seeking skills or necessary retraining. Is the injured worker a candidate for vocational rehabilitation services focusing on return to work?  Yes  No. If no, please explain why and provide your recommendations to help the injured worker return to employment.

**Treating physician signature - mandatory**

8 I certify the above information is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain payment as provided by BWC or who knowingly accepts payment to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Treating physician's name (please print legibly)			Physician PEACH number	
Address	City	State	Nine-digit ZIP code	Telephone number - -
Treating physician signature			Date	Fax number - -



The next few pages will provide you with locations in Franklin and all of the surrounding counties in which you may seek medical treatment if necessary. Local providers offer occupational health centers around central Ohio.

Reasons to visit and Occupational Health Center or Urgent Care:

- ⊕ Specializes in occupational medicine
- ⊕ Quicker service-no emergency room waiting
- ⊕ Effective for treating cuts, abrasions, lacerations and wounds requiring stitches
- ⊕ Also treats fractures, rashes and minor burns.

## Downtown

### **WorkHealth Downtown**

895 W. 3<sup>rd</sup> Ave.  
Columbus, Ohio 43212  
614-566-9191  
Monday-Friday 7:30am -4:30pm

### **OhioHealth Urgent Care-Victorian Village**

1132 Hunter Ave  
Columbus, Ohio 43201  
614-544-0822  
Mon-Fri 9am-7pm Sat-Sun 9am-5pm

## North

### **WorkHealth North**

300 Polaris Parkway  
Westerville, Ohio 43082  
614-566-9675  
Monday-Friday 7:30am-4:30pm

### **AccessMD Urgent Care-Cintonville**

4400 North High Street  
Columbus, Ohio 43214  
614-263-4400  
Mon-Fri 9am-7:30pm Sat-Sun 9am-5pm

### **OhioHealth Urgent Care-Dublin**

6905 Hospital Drive  
Dublin, Ohio 43016  
614-923-0300  
Monday-Sunday 9am-9pm

## East

### **Mt. Carmel Urgent Care**

6435 East Broad Street  
Columbus, Ohio 43213  
614-355-8150  
Mon-Fri 9am-9pm Sat-Sun 9am-6pm

### **OhioHealth Urgent Care-Gahanna/New Al**

5610 North Hamilton Road  
Columbus, Ohio 43230  
614-775-9870  
Monday-Sunday 8am-8pm

### **AccessMD Urgent Care-Stelzer Rd**

2880 Stelzer Road  
Columbus, Ohio 43219  
614-472-2880  
Mon-Fri 8:30am-7:30pm Sun-Sun 9am-5pm

### **AccessMD Urgent Care-Groveport**

3813 S. Hamilton Road  
Groveport, Ohio 43125  
614-835-0400  
Mon-Fri 8am-8pm Sat-Sun 9am-5pm

### **OhioHealth Urgent Care-Reynoldsburg**

2014 Baltimore-Reynoldsburg Road  
Reynoldsburg, Ohio 43068  
614-522-6900  
Monday-Sunday 9am -7pm

## West

### **WorkHealth West**

4523 Cemetery Road

Hilliard, Ohio 43026

614-566-9675

Monday-Friday 7am -4pm

### **AccessMD Urgent Care Clime Road**

4300 Clime Road

Columbus, Ohio 43228

614-272-1100

Mon-Fri 8am -8pm Sat-Sun 9am -5pm

### **AccessMD Urgent Care Hilliard**

5677 Scioto Darby Road

Hilliard, Ohio 43206

614-921-0648

Mon-Fri 8:30am-7:30pm Sat-Sun 9am-5pm

## South

### **WorkHealth Southwest**

4079 Gantz Road, Suite C

Grove City, Ohio 43123

614-566-9675

Monday-Friday 7am -4pm

### **OhioHealth Urgent Care-Grove City**

2030 Stringtown Road

Grove City, Ohio 43123

614-883-0160

Monday-Sunday 9am-Midnight

## **Delaware County**

### **OhioHealth Urgent Care-Lewis Care**

24 Hidden Ravines Drive  
Powell, Ohio 43065  
740-549-2700  
Monday-Sunday 9am-7pm

### **Wedgewood Urgent Care**

10330 Sawmill Parkway  
Powell, Ohio 43065  
614-923-9200  
Mon-Fri 9am-9pm Sat-Sun 9am-6pm

### **WorkHealth Delaware**

801 OhioHealth Blvd.  
Delaware, Ohio 43015  
614-566-9675  
Monday-Friday 8am-4:30pm

### **AccessMD Urgent Care-Delaware**

1100 Sunbury Road #706  
Delaware, Ohio 43015  
740-363-3133  
Mon-Fri 9-7:30pm Sat-Sun 9am-5pm

### **Sunbury Urgent Care**

101 West Cherry Street Suite D  
Sunbury, Ohio 43074  
740-965-8305  
Mon-Fri 9am-9pm Sat-Sun 9am-6pm

## **Fairfield County**

### **Access Urgent Medical Care**

1797 Hill Road North  
Pickerington, Ohio 43147  
614-833-6002  
Monday-Sunday 8am-8pm

## **Licking County**

### **Newark Valley Urgent Care**

1906 Tamarack Road  
Newark, Ohio 43055  
740-522-0222  
Mon-Fri 9am-9pm Sat-Sun 9am-6pm

## **Pickaway County**

### **PHS Occupational Health**

1434 Circleville Plaza  
Circleville, Ohio 43113  
740-420-7975  
Monday-Friday 8am-4:30pm

## **Union County**

### **Memorial Hospital Urgent Care**

1140 Charles Lane  
Marysville, Ohio 43040  
937-578-4310  
Mon-Fri 9am-9pm Sat-Sun 9am-6pm

## Hospitals & Emergency Rooms

### **Columbus:**

Riverside Methodist Hospital  
3535 Olentangy River Rd.  
Columbus, Ohio 43214  
(614) 566-5000

Grant Medical Center  
111 S Grant Avenue  
Columbus, Ohio 43215  
(614) 566-9000

Doctors Hospital  
5100 West Broad Street  
Columbus, Ohio 43228  
(614) 544-1000

Dublin Methodist Hospital  
7500 Hospital Drive  
Dublin, Ohio 43016  
(614) 544-8000

OSU Hospital  
410 W. 10<sup>th</sup> Ave.  
Columbus, Ohio 43210  
(614) 293-8000

University Hospital East  
1492 E. Broad St. Columbus, OH 43205  
(614) 257-3000

Mount Carmel West  
793 West State Street  
Columbus, Ohio 43222  
(614) 234-5000

Mount Carmel East  
6001 East Broad Street  
Columbus, Ohio 43213  
(614) 234-6000

Mount Carmel St. Ann's  
500 South Cleveland Avenue  
Westerville, Ohio 43081  
(614) 898-4000

Mount Carmel New Albany Surgical Hospital  
7333 Smith's Mill Road  
New Albany, Ohio 43054  
(614) 775-6600

### **Delaware:**

Grady Memorial Hospital  
561 West Central Avenue  
Delaware, Ohio 43015  
(740) 615-1000

### **Licking:**

Licking Memorial Hospital  
1320 West Main Street  
Newark, Ohio 43055  
(740) 348-4000

### **Fairfield:**

Fairfield Medical Center  
401 North Ewing St.  
Lancaster, Ohio 43130  
(740) 687-8000

### **Pickaway:**

Berger Health System  
600 North Pickaway Street  
Circleville, OH 43113  
(740) 474-2126

### **Madison:**

Madison County Hospital  
210 North Main Street  
London, Ohio 43140  
(740) 845-07000

### **Union:**

Memorial Hospital of Union County  
500 London Avenue  
Marysville, Ohio 43040  
(937) 644-6115 (800) 686-4677