



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
614-525-4642
Or fax to: 614-525-5715

Jenell Williams, Business Service Officer
jwillia@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

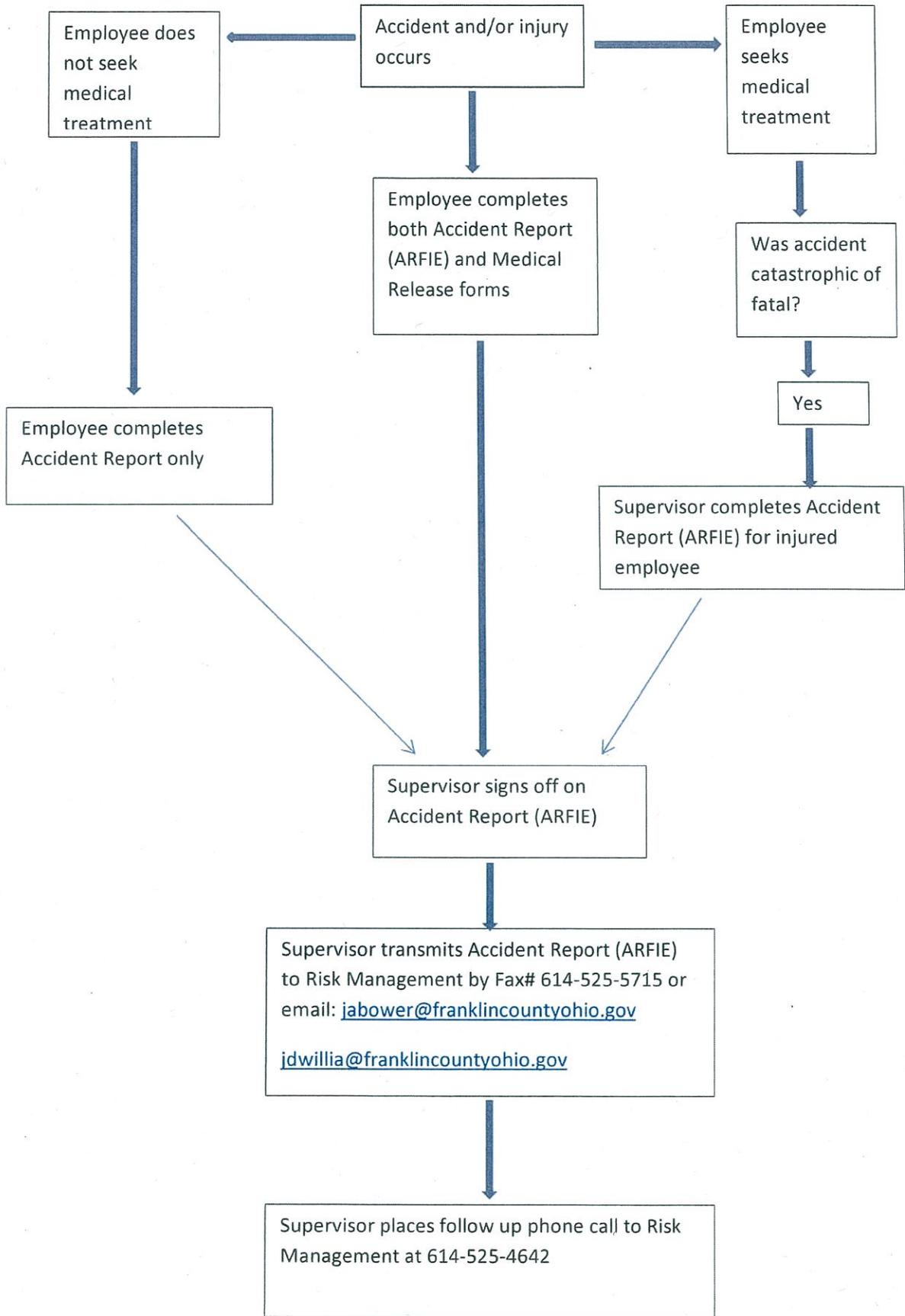


2015 INJURY PACKET

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. 3-5-12

AGENCY:	FRANKLIN COUNTY SI RISK NO. 20005728	(Risk Mgt. USE ONLY)
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EMPLOYEE'S INFORMATION:

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

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

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

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

1 _____	6 _____
2 _____	7 _____
3 _____	8 _____
4 _____	9 _____
5 _____	10 _____

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

Employee Signature	Date
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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.

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

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:

1.	3.
2.	4.

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

If yes, provide their names:

1.	3.
2.	4.

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?	SERIAL NO:

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	STREET ADDRESS	CITY, STATE, ZIP	CONTACT PERSON	TELEPHONE

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.

Effective April 1, 2012 Risk Management. Fax to 614-525-5715, then call 614-525-4642 to Report New Injury



Instructions

You can obtain this form online at www.bwc.ohio.gov

- 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.

Injured worker name (first, M.I., last)		Date of injury	Claim number
Address	City	State	Nine-digit ZIP code
Employer name FRANKLIN COUNTY COMMISSIONERS	Employer MCO or OHP SELF INSURED EMPLOYER	20005728	

I, the above-named injured worker, understand I am allowing the Opportunities for Ohioans with Disabilities 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.

Injured worker (or guardian or personal representative) signature	Date
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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

Telephone

(7) Name

Address

Telephone

(8) Name

Address

Telephone

(9) Name

Address

Telephone

(10) Name

Address

Telephone



**WORKERS' COMPENSATION & INJURY
IDENTIFICATION INFORMATION
EFFECTIVE: APRIL 1, 2012**

**THIS FORM IS FOR THE
INJURED EMPLOYEE**
Employer Risk Number is 20005728-0.

**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 and click on "Pharmacy Locator."

Questions? Need Help?



866.599.5426

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

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>	or	<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 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

The injured worker is progressing: As expected Better than expected Slower than expected

1 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	N O F C				Pushing/pulling	N O F C				Activity	N O F C				Activity	N O F C			
	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.

Activities of daily living: Self-care, personal hygiene, communication, ambulation, travel, sexual function, sleep, social and recreational activities and occupational functioning	None	Mild	Moderate	Marked	Extreme
Activities of daily living: Self-care, personal hygiene, communication, ambulation, travel, sexual function, sleep, social and recreational activities and occupational functioning	<input type="checkbox"/>				
Social functioning: Capacity to interact and communicate effectively and get along with others	<input type="checkbox"/>				
Concentration, persistence and pace: Ability to sustain focused attention long enough to complete tasks commonly found in the workplace	<input type="checkbox"/>				
Adaptation: 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

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.

5

Maximum medical improvement (MMI)

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

6 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

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?

7 Yes No If no, please explain why and provide your recommendations to help the injured worker return to employment.

Treating physician signature - mandatory

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.

8	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 an 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. 3rd 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-Clintonville

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. 10th 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