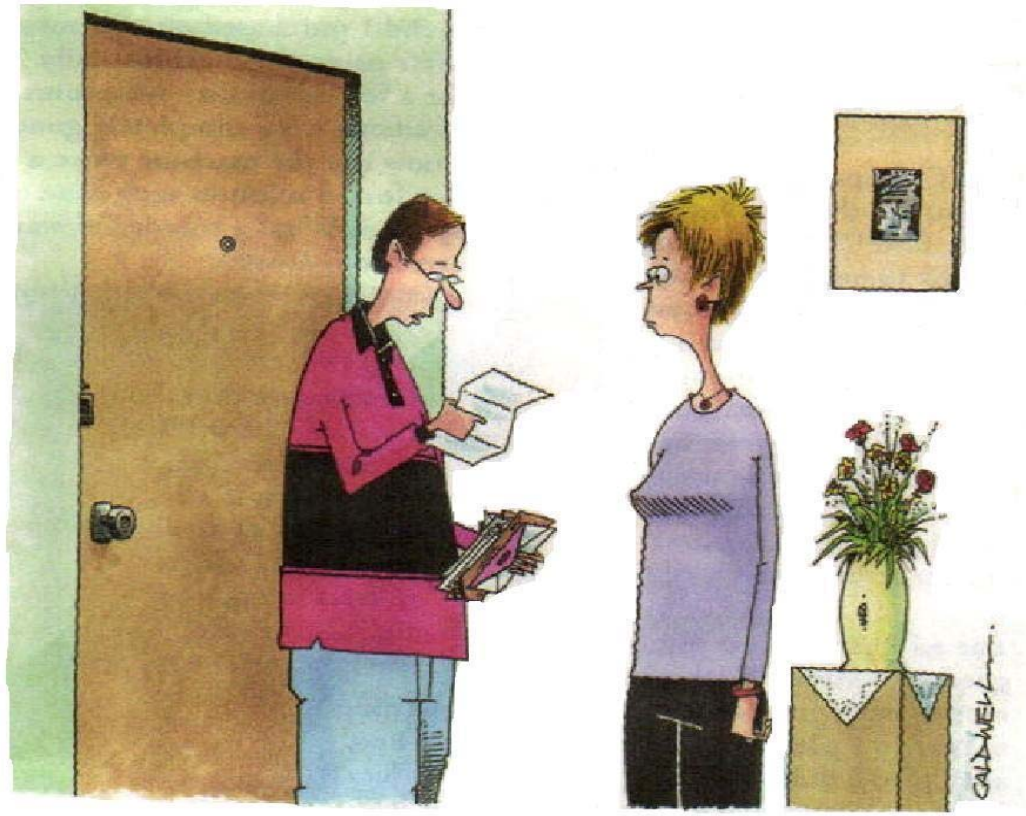
How to Get the Most Out of Your Industrial Commission Hearing*

*With or Without A Lawyer

By: Michael J. Bertsch
Moscarino & Treu LLP



"Well, this is a first. We've been predeclined for a credit card."

Telltale Troublesome Claims and Claimants

Telltale Troublesome Claims and Claimants or

Telltale Troublesome Claims and Claimants

or

How to Spot The Exception From The Rule


WHY AREN'T YOU WORKING ?
I DIDN'T SEE YOU COMING !

Exceptions = Trouble

* New Hire Claimant

Exceptions = Trouble

* New Hire Claimant

* Problem Employee / Multiple Claimant

Exceptions = Trouble

* New Hire Claimant

* Problem Employee / Multiple Claimant

* No or Late Reporting of Incident

Exceptions = Trouble

* New Hire Claimant

* Problem Employee / Multiple Claimant

* No or Late Reporting of Incident

* No Witnesses When There Should Be

Exceptions = Trouble

* New Hire Claimant

* Problem Employee / Multiple Claimant

* No or Late Reporting of Incident

* No Witnesses When There Should Be

* Lawyer – Early On

Investigation:

FACTS

* Accident Report

1) Form
2) Statements – Claimant / Witness

+

3) Photographs
4) Reasonable Suspicion Evidence
5) Video
6) Machine Information

BWC
Better Workers' Compensation
Built with you in mind

Governor Bob Taft
Administrator/CEO James Conrad

First Report of an Injury, Occupational Disease or Death

WARNING:
Any person who obtains compensation from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false statements or accepting compensation to which he or she is not entitled, is subject to felony criminal prosecution for fraud.
(R.C. 2913.48)

Injured worker and injury/disease/death info.

Last name, first name, middle initial			Social Security number	Marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Date of birth				
Home mailing address			Sex ☐ Male ☐ Female	Number of dependents
City	State	9-digit ZIP	Country if different from USA	Department name
Wage $ _____ Per: ☐ Hour ☐ Month ☐ Week ☐ Year ☐ Other _____			What days of the week do you usually work? ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat	Regular work hours From _____ To _____
Have you been offered or do you expect to receive payment or wages for this claim from anyone other than the Ohio Bureau of Workers' Compensation? ☐ Yes ☐ No If yes, please explain.				Occupation or job title
Employer name				
Mailing address (number and street, city or town, state, ZIP code and county)				
Location, if different from mailing address				
Was the place of accident or exposure on employer's premises? ☐ Yes ☐ No (If no, give accident location, street address, city, state and ZIP code)				
Date of injury/disease	Time of injury _____ ☐ a.m. ☐ p.m.	If fatal, give date of death	Time employee began work _____ ☐ a.m. ☐ p.m.	Date last worked / Date returned to work
Date hired	State where hired		Date employer notified	
Description of accident (Describe the sequence of events that directly injured the employee, or caused the disease or death.)			Type of injury/disease and part(s) of body affected (For example: sprain of lower left back)	

Benefit application/medical release *– I am applying for recognition of my claim under the Ohio Workers' Compensation Act for work-related injuries that I did not purposely inflict. I request payment for compensation and/or medical expenses as allowable. Direct payment(s) to the providers of any medical services are authorized. I understand that I am allowing any provider who attends to, treats or examines me to release all medical, psychological and/or psychiatric information that is causally or historically related to physical or mental injuries relevant to issues necessary to the administration of my workers' compensation claim to the Ohio Bureau of Workers' Compensation, the Industrial Commission of Ohio, the employer listed in this claim, that employer's managed care organization and any authorized representatives. I further authorize the Ohio Rehabilitation Services Commission to release information about my physical, mental, vocational and social conditions that is causally or historically related to physical or mental injuries relevant to issues necessary for the administration of my workers' compensation claim to the aforementioned parties.*

Injured worker signature	Date	E-mail address	Telephone number ( )	Work number ( )

Treatment info.

Health-care provider name	Telephone number ( )	Fax number ( )	Initial treatment date
Street address	City	State	9-digit ZIP code
Diagnosis(es): Include ICD code(s)			
Will the incident cause the injured worker to miss eight or more days of work? ☐ Yes ☐ No	Is the injury causally related to the industrial incident? ☐ Yes ☐ No		
Health-care provider signature	11-digit BWC provider number	Date	

Employer info.

Employer policy number	Check if ☐ Employer is self-insuring ☐ Injured worker is owner/partner/member of firm			
Telephone number ( )	Fax number ( )	E-mail address	Federal ID number	Manual number
Was employee treated in an emergency room? ☐ Yes ☐ No	Was employee hospitalized overnight as an inpatient? ☐ Yes ☐ No			
If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code				

☐ **Certification** - The employer certifies that the facts in this application are correct and valid.

☐ **Rejection** - The employer rejects the validity of this claim for the reason(s) listed below:

For self-insuring employers only

☐ **Clarification** - The employer clarifies and allows the claim for the condition(s) below:
☐ **Medical only** ☐ **Lost time**

Employer signature and title	Date	OSHA case number

BWC-1101 (Rev. 9/2003)
FROI-1 (Combines C-1, C-2, C-3, C-6, C-50, OD-1, OD-1-22)

This form meets OSHA 301 requirements

INDUSTRIAL COMMISSION OF OHIO
BUREAU OF WORKERS' COMPENSATION

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Claim Number: _____

Date of Injury: ____/___/_____

Claimant's Name: _____

Social Security Number: _____

Employer's Name

Nature of Injury or Condition:_____

_____

_____

_____

_____

As provided by Section 4123.651(C) of the Ohio Revised Code, I hereby permit the release of medical information, records and reports relative to the issues necessary for the Administration of my Workers' Compensation claim to the Industrial Commission of Ohio, Ohio Bureau of Workers' Compensation or the condition either allowed or requested in my claim, or to consider the payment or to determine the eligibility of payment of compensation and medical benefits under my workers' compensation claim.

A copy of this release is as valid as the original.

_____
Signature of Claimant

___/___/_____
Date

1) Have you received treatment for this condition or injury? YES / NO
   a) If so, at what medical facility or with what physician or chiropractor did you receive treatment?_____

2) Have you ever had a similar condition or problem in the past? YES / NO
   a) If so, when did you experience similar problems? _____
   b) Did you seek medical treatment at that time? YES / NO
      If so, with whom did you seek treatment? _____

3) Have you ever been treated by a chiropractor? YES / NO
   a) If so, what condition were you treated for ? _____
      Which chiropractor were you treated by? _____

EMPLOYEE'S STATEMENT

I, _____, certify that on ___/___/____ at ___:___ A.M./P.M.,

I sustained an injury to my _____ which occurred as follows:
(Part of Body)

_____

_____

_____

_____
(Describe the accident in detail, stating part of body injured)

Occupation_____ Dept_____ Age_____ Gender: Male/Female

Where did accident occur? _____
(On company property, dept, plant, etc.)

Name(s) of witnesses:_____

I reported this accident on ___/___/____ at ___:___ A.M./P.M. to _____

Hospital and/or Doctor:_____
(Include mailing address)

Have you had any previous accidents? Yes/No If yes, when?_____

___/___/____ _____
(Date) (Signature Of Employee)

_____ ____-___-____
(Street Address) (Social Security #)

_____ (___) ___-____
(City, State, Zipcode) (Phone)

3/25/98 AccidentForm.xls:3EmpStmnt

SUPERVISOR'S REPORT

Fill out Page 1 Immediately , while all details are fresh and readily obtainable.

ACCIDENT REPORT ANALYSIS	PART 1 - THE FACTS	
I. Time & Place Injured:		
Name:	Soc. Sec. #: ___-___-____	Gender: [ ] M / [ ] F
Department:	Job Title:	
Date of Accident: ___/___/___	Where Accident Occurred:	

II. DESCRIPTION OF THE ACCIDENT (List All Parts of the Body & Machinery Involved):

(Use blank paper if more space is needed)

Protective Gear Employee Had On:	Nature of the Accident
[ ] Glasses [ ] Ear Muffs [ ] Spats [ ] Jacket [ ] Other _____	[ ] Fell [ ] Struck by _____ [ ] Tripped [ ] Shock [ ] Slipped [ ] Burn [ ] Caught in or between _____ [ ] Other _____

III. WITNESSES:

NameS of Witnesses:	Their Location at the Time of the Accident:
1	
2	
3	

IV. ACTION TAKEN:

Medical Attention Given

Injured Party Taken To:

Hospital/Clinic Name:_____by (ambulance,car,etc.)_____

Taken Date & Time:_____/___/_____:____ AM / PM

Time of Return to Basic, or _____:____ AM / PM

estimated date of return: ___/___/___

Lost Hours/Time: ____:____

Was First Aid Applied at Basic Aluminum? [ ] Yes / [ ] No

V. CORRECTIVE ACTION TAKEN TO PREVENT RECURRENCE OF THIS PROBLEM:

STATEMENT OF WITNESS TO ACCIDENT

I. INCIDENT IDENTIFICATION INFORMATION

Name of employee alleging incident_____ Shift_____

Occupation_____ Department_____

II. WITNESS' STATEMENT

Your name has been given as a witness to an incident alleged by the above individual. Through your cooperation information can be obtained to complete the investigation of this incident. Therefore, it will be appreciated if you will answer each of the following questions and promptly return your completed statement.

Your name_____ Your occupation_____

Your address_____ Your telephone number ( )____-____

_____

Did you see an accident occur involving the above employee? ☐ Yes ☐ No

If not, how did you learn about the accident?_____

_____

If you did see an accident occur:

Date of accident____/____/____ Time of accident_____ ☐ AM ☐ PM

Describe what you observed_____

_____

_____

_____

Your signature_____ Date ____/____/____

State of Ohio

County of _____ ss:

Before me, a Notary Public in and for said state, personally appeared the above named who acknowledged before me that he/she did sign the foregoing instrument and that the same is his/her free act and deed.

In testimony whereof, I have hereunto affixed my name and official seal at _____, Ohio, this _____ day of _____, 19____.

(signed)_____

(SEAL) Name (printed or typed)_____

Notary Public, State of Ohio

My Commission Expires _____(date)

PUBLIC RECORDS

- B W C – O.P.E.N. Online
- B M V
- Court Records
  - Criminal / Traffic
  - Civil / Personal Injury

Ohio Bureau of Workers Compensation

Return to Selection Menu | Record Help

Access : **Representative**

Date Searched : **07/28/2006**

Selection : **SSN Search**

SSN : [redacted]

To disconnect from the Ohio BWC system, please click the log-off button.

Log-off BWC

Social Security Search

Click the circle next to the Claim Nbr and then click on the appropriate Sub Request

Claim Nbr	Injured Worker	Date of Injury	Archived	Source	Status
97[redacted]	[redacted]	02/10/1997			
06[redacted]	[redacted]	06/01/2006			
04[redacted]	[redacted]	03/10/2004			
00[redacted]	[redacted]	09/13/2000			

(F2) Selection Menu

(F4) Claim Location | (F5) Claim Status | (F6) Injured Worker

Contact Customer Support for assistance at 1-800-366-0106

A

Ohio - Driving Record Detail

State Selection Screen | Choose a State | Go | Search Screen | Record Help

SSN : [redacted]

Date Searched : 03/03/2006

Driver Information

Name :
SSN : DOB :
License Nbr : Issue Date : 08/19/2003 Expire Date : 07/01/2007
Address :

Gender : FEMALE Height : 5'03" Weight : 175
Hair : BLACK Eyes : BROWN
Lic Class : OPERATOR

License Information

Lic Status : VALID Status Date : 03/03/2006

Driving Record Detail

Record Group : Conviction
Record Type : IN-STATE CONVICTION
Court Case Nbr : [redacted] Court Name : EUCLID MUNICIPAL COURT
Offense Desc : FAIL CONTROL 4511.202 County :
Offense Date : 01/16/2004 Convicted Date : 01/28/2004
Accident Date : Points Assessed : 02
Suspended From : Suspended To :
FRA Start : FRA End :
Withdrawal :

Record Group : Accident
Record Type :
Court Case Nbr : Court Name :
Offense Desc : County : CUYAHOGA
Offense Date : Convicted Date :
Accident Date : 06/20/2005 Points Assessed :
Suspended From : Suspended To :
FRA Start : FRA End :
Withdrawal :

TRAFFIC CRASH REPORT

OHIO PUBLIC SAFETY

2 [redacted]

Crash Severity: 2 (1 Fatal, 2 Injury, 3 PDO, 4 Unknown)

Private Property

Hit/Skip: 2 (1 Not Hit/Skip, 2 Solved, 3 Unsolved)

Photos Taken: X

OH-2 | OH-3 | OH-1P | Other

Reporting Agency #: 18630 — CLEVELAND METROPARKS RANGER DEPT.

01 01 — 01162004

Day of Week: FRI — 0844 — X

Name of City, Village or Township #: EUCLID — 18

Latitude | Longitude

Crash Occurred On: EUCLID CREEK PARKWAY — Type Loc: 1

Type Location Point Used: 1 Named Street, 2 Numbered Route, 3 Numbered Street

Local Information #: CRASH #: [redacted]

Dist Reference: 1 (M) S — Reference: HIGHLAND ROAD — Ref Point: 02

Reference Point Used: 01 State Line, 02 Intersection 2 Streets, 03 County Line, 04 House Number, 05 Township Boundary, 06 Mile Post, 07 Corporation Limit, 08 Place Name W/O Reference, 09 Driveway, 10 Street or Route W/O Reference

Motorist/Non-Motorist

01 01 — Name (Last, First, Middle): [redacted]

Address (Street, City, State, Zip Code): [redacted] SOUTH EUCLID, OHIO 44121

07011960 — 43 — F — Home Phone #: [redacted] — Work Phone #

DL State: OH — DL #: [redacted] — LP State: OH — LP #: [redacted]

Injured Taken By: 2 (1 None, 2 EMS, 3 Police, 4 Other, 5 Unknown) — Transported By: EMS — EUCLID GENERAL — Injured Taken To: EUCLID GENERAL

Owner Name (If Same, Write "Same"): [redacted] — Address (Street, City, State, Zip Code): SAME

Year: 1992 — Make: MERCEDES — Model: 190 — Color: BLACK — Insurance Company: GRANGE — Towing Service: KNIGHTS — Owner Phone #: 216-[redacted]

Offense Charged: FAILURE TO CONTROL — Offense Description: 331.27 A — 287345

Name (Last, First, Middle)

Address (Street, City, State, Zip Code)

Home Phone # — Work Phone #

DL State | DL # | LP State | LP # | Injured Taken By: 1 None, 2 EMS, 3 Police, 4 Other, 5 Unknown | Transported By | Injured Taken To

Owner Name (If Same, Write "Same") | Address (Street, City, State, Zip Code)

Year | Make | Model | Color | Insurance Company | Towing Service | Owner Phone #

Offense Charged | Offense Description

Occupant

Name (Last, First, Middle) — Home Phone #

Address (Street, City, State, Zip Code) — 264 — Injured Taken By: 1 None, 2 EMS, 3 Police, 4 Other, 5 Unknown — Transported By — Injured Taken To

Name (Last, First, Middle) — Home Phone #

Address (Street, City, State, Zip Code) — Injured Taken By: 1 None, 2 EMS, 3 Police, 4 Other, 5 Unknown — Transported By — Injured Taken To

01 — Seating Position: 01 Front – Left (MC Driver), 02 Front – Middle, 03 Front – Right, 04 Second – Left (MC Pass), 05 Second – Middle, 06 Second – Right, 07 Third – Left (MC Passenger/Side Car), 08 Third – Middle, 09 Third – Right, 10 Sleeper Section of Cab, 11 Enclosed Cargo Area, 12 Unenclosed Cargo Area, 13 Trailing Unit, 14 Exterior, 15 Other, 16 Non-Motorist, 17 Unknown

04 — Safety Equipment: Motorist: 01 None Used, 02 Shoulder Belt Only, 03 Lap Belt Only, 04 Shoulder/Lap Belt, 05 Child Safety Seat, 06 MC Helmet Used, 07 Use Unknown; Non-Motorist: 08 None Used, 09 Helmet Used, 10 Protective Pads, 11 Reflective Clothing, 12 Lighting, 13 Other, 14 Unknown

2 — Air Bag: 1 Not Deployed, 2 Deployed-Front, 3 Deployed-Side, 4 Deployed Both Front/Side, 5 Not Applicable, 6 Unknown

4 — Air Bag Switch: 1 Not Present, 2 In On Position, 3 In Off Position, 4 Unknown

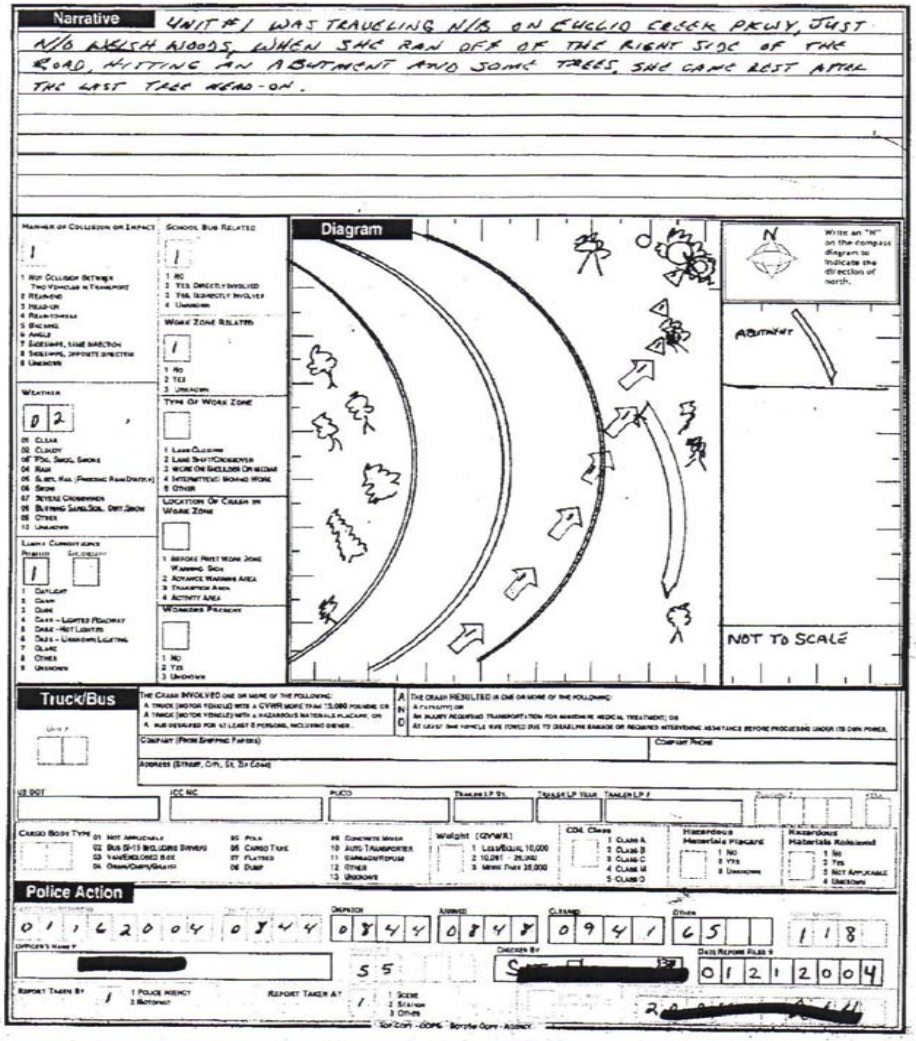
1 — Ejection: 1 Not Ejected, 2 Totally Ejected, 3 Partially Ejected, 4 Not Applicable, 5 Unknown

1 — Trapped: 1 Not Trapped, 2 Extricated By Mechanical Means, 3 Freed By Non-Mechanical Means, 4 Unknown

2 — Injuries: 1 No Injury, 2 Possible, 3 Non-Incapacitating, 4 Incapacitating, 5 Fatal Injury, 6 Unknown

Blank for Witness

Top Copy - ODPS — Bottom Copy - Agency



Narrative

UNIT #1 WAS TRAVELING N/B ON EUCLID CREEK PKWY, JUST N/O ENGLISH WOODS, WHEN SHE RAN OFF OF THE RIGHT SIDE OF THE ROAD, HITTING AN ABUTMENT AND SOME TREES, SHE CAME REST AFTER THE LAST TREE HEAD-ON.

Diagram

N

ABUTMENT

NOT TO SCALE

Truck/Bus

Police Action

Public Access System

Cuyahoga Falls Municipal Court
Clerk's Computerized Public records

City of Stow Vs BRIAN E ECKLEY

Docket for Case Number : 2004TRD08569

Date	Description
	Case # : 2004TRD08569
	Case filed on : 07/01/2004 Date of violation : 07/01/2004
	Filing agency : City of Stow Officer badge : 733
	Ticket # : 96586 Ticket location :
	Violator name : BRIAN E ECKLEY
	Violator address : 654 BETTES AVE AKRON OH-44310
	Vehicle identification : OH BK7V
	Applicable violations :
	(1) 333.03D2 SPEEDING Degree : MM
	Attorney last name : HART
	Original plea : NG
	Final plea : G
	Chg Sentence : Plea Changed to Guilty; Found Guilty of Amend Date : 08/05/2004
	Fine & costs : 162.00 Total amount to pay : 162.00
	Receipt no : 00517412 Date : 08/05/2004 Amount : 162.00
	Activities:
07/02/2004	Initial Court Date: 07/07/2004 Initial Court Time: 08:30AM
	New Arraignment hearing held. Judge: John W Clark
	Plea of Not Guilty on violation 01: (333.03D2 SPEEDING)
	Judge: Kim R Hoover,Auto Assigned - Control Number: 94417.
	Date Arrested Set To: 07/01/2004
	Time Waived Filed on: 07/02/2004
07/06/2004	7/6/04 SET TRIAL 8/5/04 WITH ATTY BY PHONE. CT NOTICE MAILED TO PTL AND PROS
	Notice: 3 Magistrate Card printed for Prosecutor
	Notice: 3 Magistrate Card printed for Officer
	Trial. scheduled before: Judge: Kim R. Hoover Assigned. On 8/5/2004 @ 02:00 PM
07/26/2004	Court room changed from SOUTH COURTROOM to HEARING ROOM A
	Judge Changed From: Kim R. Hoover to John W. Clark
08/05/2004	Case Sentence Order
	Receipt number : 00517412 Date : 08/05/2004 Amount : $162.00
	Section: 333.03D2 - SPEEDING
	Plea: Guilty on 08/05/2004

CITY OF STOW
CUYAHOGA FALLS MUNICIPAL COURT, SUMMIT COUNTY, OHIO
SUMMIT COUNTY JUVENILE COURT
STATE OF OHIO

COURT CASE NUMBER

NAME [illegible]
STREET [illegible]
CITY, STATE [illegible]
LICENSE ISSUED MO. 3-13 YR. 04 EXPIRES BIRTHDATE 20 STATE
SSN D.O.B. MO. DAY
RACE SEX HEIGHT WEIGHT HAIR EYES FINANCIAL RESPONSIBILITY PROOF SHOWN

LICENSE NO.
LIC. CLASS DOT # Does Not Apply

TO DEFENDANT: COMPLAINT

ON 7-1 20 04 AT 0053 A.M. YOU OPERATED/PARKED/WALKED A
VEHICLE YR. MAKE BODY TYPE 750
COLOR BLUE/WHITE LIC. STATE OH
UPON A PUBLIC HIGHWAY, NAMELY SR 8
AT/BETWEEN 10.2 MM S/B
IN THE CITY OF STOW
COUNTY NO. 77, STATE OF OHIO AND COMMITTED THE FOLLOWING OFFENSE:

SPEED 112 MPH in 65 MPH zone
Radar / Air / VASCAR / Pace / Laser
OVI: Under the influence of alcohol/drug of abuse
DRIVER LICENSE: None / Revoked / Suspended
SAFETY BELT – Failure to wear: Driver / Passenger / Child Restraint
OTHER OFFENSE
OTHER OFFENSE

DANGER: VEHICLE HELD / VEHICLE SEIZED
PAVEMENT: Dry / Wet / Snow / Icy
VISIBILITY: Clear / Cloudy / Dusk / Night
WEATHER: Rain / Snow / Fog
TRAFFIC: Heavy / Moderate / Light / None
AREA: Business / Rural / Residential / Industry / School
CRASH: Yes / No

Ticket No. 04-11035

ACCOMPANYING CRIMINAL CHARGE: Yes / No

TO THE DEFENDANT: SUMMONS

---

less than four miles port acc/ hemedy dev

TTD

REPORT OF ACTION ON CASE

DATE OF ARREST ______ (Month, Day, Year) ______ (Time) M

COURT ACTION

- ☐ GUILTY
- ☐ NOT GUILTY
- ☐ RELEASED TO OTHER AUTHORITY
- ☐ ______

OFFICER NOTES

Radar # B&G III 66Y 000 4046. Time 2345

Laser # Cal. Time 0115

THE DEFENDANT WAS S/B ON SR 8. THE DEFENDANT'S M/C WAS CLOCKED AT 112 M.P.H. IN A POSTED 65 M.P.H. ZONE. TRACKING WAS 112 M.P.H. DROPPED TO 99, 98 M.P.H. PASSENGER ON M/C STATED HE THOUGHT HE WAS GOING 88 MPH ALSO STATED HE MODIFY THE BIKE REAR TIRE.

WITNESSES:

Name Address Phone No.

Name Address Phone No.

VIOLATOR:

SCALE LOCATION: ______ ☐ PLATFORM ☐ PORTABLE

AMOUNT OF OVERLOAD

OVERLOADED ☐ Single Axle ☐ Tandem ☐ Gross — Length: # groups

ON:

☐ PUCO NO. ______

Permit Holder or Company Name of Vehicle Owner Name

Street Address

City State Zip

NOTIFICATION OF ARREST ONLY.

less than four mults port acc/ Kendall dir

REPORT OF ACTION ON CASE

DATE OF ARREST ______ Month, Day, Year ______ Time

COURT ACTION

☐ GUILTY ☐ RELEASED TO OTHER AUTHORITY TTD

☐ NOT GUILTY ☐ ______

OFFICER' NOTES

B16 III

Radar # 464 and 4046 Times 2345

Laser # Cal. Times 0125

THE DEFENDANT WAS S/B ON
SR 18. THE DEFENDANT'S M/C
WAS CLOCKED AT 112 M.P.H. IN
A POSTED 65 M.P.H. ZONE. TRACKING
SPEED 112 M.P.H. DROPPED TO
99, 98 M.P.H. PASSENGER ON
M/C STATES HE THOUGHT HE WAS
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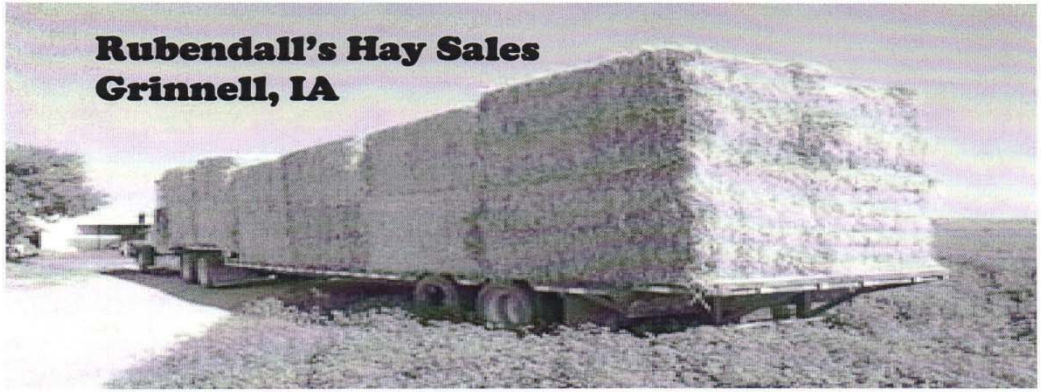
MODIFY THE BIKE REAL FAST.

WITNESSES:

Name Address Phone No.

Name Address Phone No.

GOOGLE



Steve Rubendall
Phone: 641-990-3200
Phone: 641-260-0463
Fax: 641-236-3958
Email: steve_70@crazyhaybiz.com

Kim Bilotta
Phone: 740-244-6639
Email:
klotta_72@yahoo.com
klotta72@crazyhaybiz.com

Welcome to Rubendall's Hay Sales. We take pride in providing a variety of hay and straw to meet the nutritious needs of your livestock. We farm around five hundred acres of various types of hay and straw each year. We use the latest in farming technology and equipment to produce small and large square bales. Iowa's top soil and climate is perfect for producing the highest quality hay and straw. We mow every 25 to 28 days to produce the highest protein levels and R.F.V. At Rubendall's Hay Sales, we are very proud of our farming heritage. This ongoing pride is evident in every product available.

Company History

Rubendall's Hay Sales is an independently owned and operated business. Steve Rubendall, Owner of Rubendall's Hay Sales, was born and raised in Grinnell, Iowa. Steve has been farming his whole life. He started farming as a child with his grandfather. After high school, Steve went to college while helping local farmers. He received a degree in Agricultural Mechanics at Hawkeye

SURVEILLANCE


JUN 8 2006
3:01:42PM


SP
JUN 8 2006
3:05:19PM


SP
JUN 8 2006
2:53:58PM


JUN 8 2006
3:02:38PM


JUN 8 2006
2:53:21PM


SP
JUN 8 2006
3:01:59PM


JUN 9 2006
7:17:24PM


JUN 9 2006
7:10:11PM


JUN 9 2006
7:11:30PM


JUN 9 2006
7:10:07PM


JUN 9 2006
7:11:27PM


JUN 9 2006
7:22:35PM


JUN 9 2006
7:11:15PM


JUN 13 2007
4:38:32 PM


FOR SALE
JUN 13 2007
4:39:15 PM


JUN 13 2007
4:40:26 PM


FOR SALE
JUN 13 2007
4:41:25 PM


JUN 13 2007
4:45:33 PM


JUN 13 2007
4:46:52 PM

4:47 pm
The subject was observed as she walked back to her side door and entered the residence. Approximately a minute later, she exited the residence wearing a different shirt and carrying a flashlight. She then continued to search in the grass

5:00 pm
The investigator observed as the subject slowly headed back toward her side door while she continued to look in the grass around the sidewalk.

5:10 pm
Surveillance was suspended.

MEDICAL INVESTIGATION

A. Signed Authorization

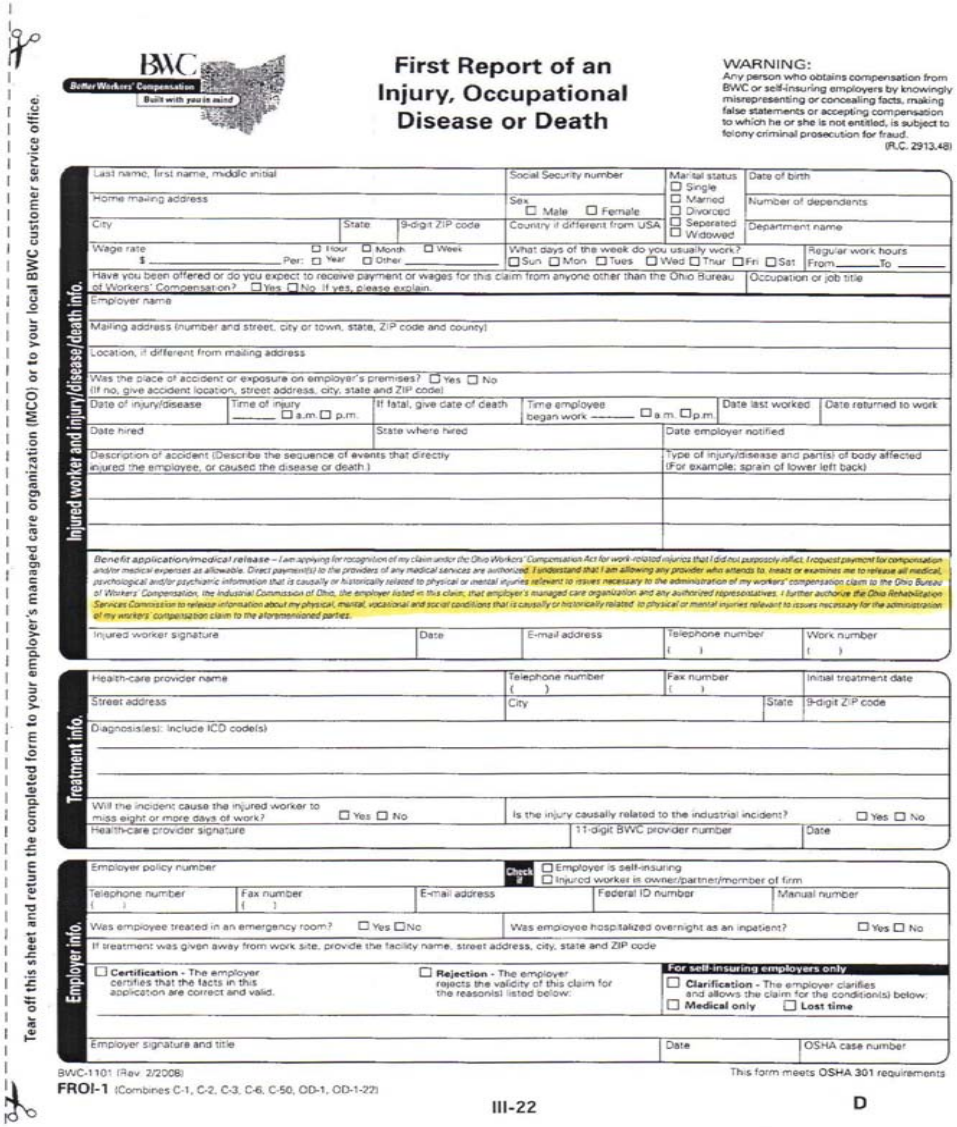
B. Historical Records

- BWC EDA
- Employment Records
- Public Records

C. Drug Test Results

D. IME/Record Review

- Review Records
- History
- Exam Findings
- Conclusions
- Report



BWC
Better Workers' Compensation
Built with you in mind

First Report of an Injury, Occupational Disease or Death

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(R.C. 2913.48)

Injured worker and injury/disease/death info.

Last name, first name, middle initial | Social Security number | Marital status ☐ Single ☐ Married ☐ Divorced ☐ Seperated ☐ Widowed | Date of birth

Home mailing address | Sex ☐ Male ☐ Female | Number of dependents

City | State | 9-digit ZIP code | Country if different from USA | Department name

Wage rate $ _____ Per: ☐ Hour ☐ Month ☐ Week ☐ Year ☐ Other _____ | What days of the week do you usually work? ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat | Regular work hours From _____ To _____

Have you been offered or do you expect to receive payment or wages for this claim from anyone other than the Ohio Bureau of Workers' Compensation? ☐ Yes ☐ No If yes, please explain. | Occupation or job title

Employer name

Mailing address (number and street, city or town, state, ZIP code and county)

Location, if different from mailing address

Was the place of accident or exposure on employer's premises? ☐ Yes ☐ No
(If no, give accident location, street address, city, state and ZIP code)

Date of injury/disease | Time of injury _____ ☐ a.m. ☐ p.m. | If fatal, give date of death | Time employee began work _____ ☐ a.m. ☐ p.m. | Date last worked | Date returned to work

Date hired | State where hired | Date employer notified

Description of accident (Describe the sequence of events that directly injured the employee, or caused the disease or death.) | Type of injury/disease and part(s) of body affected (For example: sprain of lower left back)

Benefit application/medical release – I am applying for recognition of my claim under the Ohio Workers' Compensation Act for work-related injuries that I did not purposely inflict. I request payment for compensation and/or medical expenses as allowable. Direct payment(s) to the providers of any medical services are authorized. I understand that I am allowing any provider who attends to, treats or examines me to release all medical, psychological and/or psychiatric information that is causally or historically related to physical or mental injuries relevant to issues necessary to the administration of my workers' compensation claim to the Ohio Bureau of Workers' Compensation, the Industrial Commission of Ohio, the employer listed in this claim, that employer's managed care organization and any authorized representatives. I further authorize the Ohio Rehabilitation Services Commission to release information about my physical, mental, vocational and social conditions that is causally or historically related to physical or mental injuries relevant to issues necessary for the administration of my workers' compensation claim to the aforementioned parties.

Injured worker signature | Date | E-mail address | Telephone number ( ) | Work number ( )

Treatment info.

Health-care provider name | Telephone number ( ) | Fax number ( ) | Initial treatment date

Street address | City | State | 9-digit ZIP code

Diagnosis(es): Include ICD code(s)

Will the incident cause the injured worker to miss eight or more days of work? ☐ Yes ☐ No | Is the injury causally related to the industrial incident? ☐ Yes ☐ No

Health-care provider signature | 11-digit BWC provider number | Date

Employer info.

Employer policy number | Check if ☐ Employer is self-insuring ☐ Injured worker is owner/partner/member of firm

Telephone number ( ) | Fax number ( ) | E-mail address | Federal ID number | Manual number

Was employee treated in an emergency room? ☐ Yes ☐ No | Was employee hospitalized overnight as an inpatient? ☐ Yes ☐ No

If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code

☐ **Certification** - The employer certifies that the facts in this application are correct and valid.

☐ **Rejection** - The employer rejects the validity of this claim for the reason(s) listed below:

For self-insuring employers only
☐ **Clarification** - The employer clarifies and allows the claim for the condition(s) below:
☐ **Medical only** ☐ **Lost time**

Employer signature and title | Date | OSHA case number

Tear off this sheet and return the completed form to your employer's managed care organization (MCO) or to your local BWC customer service office.

BWC-1101 (Rev. 2/2008)
FROI-1 (Combines C-1, C-2, C-3, C-6, C-50, OD-1, OD-1-22)

This form meets **OSHA 301** requirements

III-22

D

AUTHORIZATION

I, _____, (SS# _____); DOB:_____) hereby authorize any and all hospitals, physicians and/or employers, to whom this Authorization or a photocopy thereof is delivered, to permit attorney Michael J. Bertsch or any other attorney and/or legal assistant from the law firm of Moscarino & Treu, L.L.P., to view, inspect and copy any and all records concerning any and all care and treatment rendered to me at any time, including, but not limited to, hospital records, correspondence, reports, memoranda, x-ray reports, test results, test reports, nurses' and/or doctors' notes, documentation relating to prescribed medication, reports pertaining to diagnosis, treatment and/or prognosis and consultation reports and/or opinions and all other written material for all admissions, inpatient, outpatient, emergency, psychiatric, psychological, and alcohol or drug related treatment or counseling and any/all personnel and employment records.

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 (HIPAA) as the request for records relates to the administration of 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 forward to the BWC by the employer.
- A copy of the medical information will be available to me or my physician of record upon request to the employer.

_____
(Claimant Name)

Date:_____

E

BWC
Better Workers' Compensation
Built with you in mind.

Authorization to Release Medical Information

*This form can be obtained online at **www.ohiobwc.com***

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 to the 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	9-digit ZIP code
Employer name	Employer MCO or QHP		

I, the above-named injured worker, understand I am allowing the Ohio Rehabilitation Services Commission and the following providers (persons or facilities) that attend, treat or examine me (list providers here)

_____

_____ ,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:

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

_____

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 (IC), the above-named employer, the employer's managed care organization (MCO) or qualified health plan (QHP) 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. However, I understand I have the right to revoke this authorization at any time, but my revocation must be submitted in writing and filed 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 (HIPAA) 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

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

_____

BWC-1224 (Rev. 3/24/2003)
C-101

MOSCARINO & TREU LLP
ATTORNEYS AT LAW

Michael J. Bertsch
mbertsch@mosctreu.com

July 11, 2008

VIA FACSIMILE ONLY
James M. Augusta, Esq.
Hearing Administrator
Industrial Commission of Ohio
Cleveland Regional Office
615 West Superior Avenue, 7th Floor
Cleveland, Ohio 44113-1898

Re: Claimant:
Employer:
Claim No.: XX-XXXXXX
D/Injury: 01/02/2008

Dear Mr. Augusta:

The undersigned represents the employer, the _____, in the above-referenced workers' compensation matter.

In that regard, the employer has requested that the claimant execute an authorization for release of medical information (copy of correspondence enclosed). To date, claimant has failed to produce a signed medical authorization and further refuses to do so. (See enclosed Affidavit).

As you know, R.C. §4123.651(C) provides that if a claimant refuses to execute a release for medical information, his right to have his claim for compensation or benefits considered, if his claim is pending before a District Hearing Officer, is suspended during the period of refusal.

Accordingly, the employer hereby requests that any and all activity on this claim be suspended until claimant provides the employer with a signed medical authorization.

By copy of this correspondence to claimant we are advising him of the foregoing.

Thank you for your attention to this matter. Should you have any questions, please do not hesitate to contact me directly.

Very truly yours,

MOSCARINO & TREU LLP
ATTORNEYS AT LAW

Michael J. Bertsch
mbertsch@mosctreu.com

July 11, 2008

VIA FACSIMILE
Ms. Ann Lischner
Hearing Administrator
Industrial Commission of Ohio
161 South High Street, Suite 301
Akron, OH 44308

Re: Claimant:
Employer:
Claim Nos.:
D/Injuries:

Dear Ms. Lischner:

This office represents _____ in the above-captioned workers' compensation matters.

In that regard, on June 11, 2004, our office requested a complete copy of claimant's chart from Dr. _____[1]. More than three months later without any response, legal assistant, Sally Long, contacted Dr. _____'s office on October 27, 2004, to inquire about our unanswered June request for records. We were initially advised that Dr. _____ had not treated claimant for her workers' compensation claim. The medical records custodian/office manager, however, volunteered that the chart did contain complaints of pain and treatment to the left upper extremity; the body part at issue in this claim. So, the June 11th request was re-sent by facsimile to Dr. _____'s medical records custodian, with a note reiterating our need for complete records to properly evaluate claimant's condition and treatment.

In accordance with O.R.C. §4123.08 and O.A.C. 4121-3-09(A)(2), we hereby request the Industrial Commission of Ohio issue a subpoena to _____, M.D. commanding the production of claimant's entire chart. The physician's refusal to release these records is in contravention of the patient authorization as well as the Workers' Compensation Act's express physician patient privilege waiver provisions.

Thank you for your courtesies and consideration. Should you have any questions, please do not hesitate to contact me.

[1] Copies of all referenced correspondence are enclosed.

PREPARE – EARLIER THE BETTER

A) Delegate vs. Abdicate

1. Coordinate/communicate with involved parties: TPA, counsel, supervisor, POR, MCO

B) Request, Collect, and Analyze Medical and Fact Evidence, e.g. Records, Job Descriptions, Photos, Statements, etc.

C) IME (?)

D) Audio/Visual Evidence (?)

E) How Much Time Will I Need to Be Ready (?): IME Schedule and Report

PREPARE – EARLIER THE BETTER (Con't.)

F) How Much Time Will the Hearing Realistically Take?

G) File All Records/Documents Intended to be Used in Advance of the Hearing

H) Live Witness(es) v. Statements

I) Audio/Visual Evidence Policy

BEFORE THE
INDUSTRIAL COMMISSION OF OHIO

[redacted], Claimant, vs. [redacted], Employer.	CLAIM NO. 05[redacted] DATE OF INJURY: July 11, 2005 **EMPLOYER'S NOTICE OF INTENT TO PRESENT AUDIO-VISUAL EVIDENCE**

The employer, [redacted], by and through its counsel, hereby notifies the Industrial Commission and claimant of its intent to present audio-visual evidence at the SHO Hearing scheduled for Tuesday, [redacted]. Annexed herewith as Exhibit "A" is a copy of said hearing notice.

Copies of the audio-visual evidence have been previously filed with the Industrial Commission and served on the attorneys for claimant. See Exhibit "B" annexed hereto.

SYNOPSIS OF THE EMPLOYER'S AUDIO-VISUAL EVIDENCE

DVD # 1

The events portrayed occurred between 2:45 and 3:20 p.m. on Thursday, [redacted].

Claimant is shown conducting business for [redacted]com without any signs of disability or discomfort. The proposed transaction she negotiated included the cost of 12.5 bales of straw/hay mix as well as the purchase of a corral gate. Quotes were

provided and claimant mentioned she was tending bar at [redacted]r in [redacted] the next day.

DVD # 2 and #3

These videos depict the same period of surveillance on Friday, [redacted]. DVD #2 contains the raw footage. DVD #3 is a condensed version containing the most relevant portions of the observed activity.

Claimant is observed in both DVDs tending bar at [redacted]s in [redacted]. [redacted]) for one hour and 44 minutes. She exhibited no physical limitations or impairments as she went about her job activities. She told the investigator that she was looking to increase her hours during a conversation.

Respectfully submitted,

MICHAEL J. BERTSCH (0016619)
KATHLEEN E. GEE (0074966)
MOSCARINO & TREU, L.L.P.
The Hanna Building
1422 Euclid Avenue, Suite 630
Cleveland, Ohio 44115
Phone: (216) 621-1000
Fax: (216) 622-1556
Email: mbertsch@mosctreu.com
kgee@mosctreu.com

Counsel for Employer
[redacted]

THE HEARING

A. Defense Theory

1. Factual
2. Medical
3. Legal

B. Overall Objective

1. Win – how defined
2. Containment

THE HEARING (Con't)

C. Who Will Represent the Employer

1. TPA
2. Lawyer

D. Who Else Needs to Attend?

E. What Main Points Should be Made?

F. Does Claimant Need to be Questioned?

G. Is a Record Needed?

APPEAL PROCESS

A. The Next Level

1. Why did we lose?
2. What do we need to do differently – de novo?
3. What other evidence should we gather?

B. Cost/Benefit Analysis

Thank you for your time and the attention you gave me. My sincere hope is that each of you will leave with at least a few insights or new information to enhance your chances for success before the Industrial Commission.

THE END