APPLICATION FOR DISABILITY LEAVE BENEFITS
EMPLOYER STATEMENT
INITIAL/SUPPLEMENTAL DISABILITY WORKSHEET

The employer shall within five (5) days of receipt of the claim forward the claim and the claim recommendation to the Department of Administrative Services, Disability Section, 30 E. Broad Street, 28th Floor, Columbus, Ohio 43215. Please notify the Disability Section when you learn of any unexpected return to work or other changes in employee's status.

Employee Name: DOB:

Agency: Payroll #:

Job Title: CBU:

Date Last Worked: Date Disability Occurred:

Date Received: Received w/in 20 Days of Date Last Worked: ☐ Yes ☐ No*
*If no, 20 Day Due Date:

Information for: ☐ **Initial application** ☐ **Extension** ☐ **Reinstatement** ☐ **Part-time**

Date employee **actually** returned to work:

Is the employee currently subject of a disciplinary investigation? ☐ Yes* ☐ No
If yes, provide answers to the following questions in the comments section on page 2:
1. The date that the investigation was initiated;
2. The basis of the investigation; and
3. Why access to the employee is necessary for completion of the investigation

One (1) year continuous service **immediately** prior to disability? ☐ Yes ☐ No*

Employee full-time? ☐ Yes ☐ No

Part-time? ☐ Yes ☐ No*

If yes, give # of hours **worked** in 12 months preceding disability? _____ hours worked

Approved medical leave or FMLA ☐ Yes ☐ No*

Was the employee on administrative leave, childbirth/adoption or suspended? ☐ Yes* ☐ No

If suspension, give type: _____

If yes, give dates: _____

Did doctor or employee indicate claim is worked related? ☐ Yes* ☐ No

Did employee indicate working for wage/profit? ☐ Yes* ☐ No

Altered forms in any way? ☐ Yes* ☐ No

Forms signed by employee and doctor? If no, obtain signature. ☐ Yes

Drug addiction or alcohol? ☐ Yes* ☐ No

Suicide or self inflicted? ☐ Yes* ☐ No

****DECENTRALIZED AGENCIES—SEND TO DAS***

Allow employee to return to work on a part-time basis: ☐ Yes ☐ No

If yes, part-time Schedule: Hours: _____ Days: _____ Weeks: _____

Allow employee to return to work in a Transitional Work Program: ☐ Yes ☐ No

If yes, temporary modifications that can be made: _____

_____

Employee's Name: _____ SS #: _____

Agency Recommendation: ☐ Approval ☐ Disapproval ☐ Dr. Review ***(send PD)***

Reasons for disapproval or Dr. review: _____

_____

_____

_____

Work-Related Claims:

Are you aware of other claims filed with BWC that may be related to this injury? ☐ Yes ☐ No

Agency Comments: _____

_____

_____

_____

Agency Contact: _____ ***Phone #:*** _____

Fax #: _____ ***E-mail address:*** _____

_____ _____

(Appointing Authority or Designee Signature) ***(Date)***

Complete this section only if processing claims through Decentralization

Claim #: _____ Diagnosis: _____

Disability Code: _____ Standard Recovery Period in Weeks: _____ Processed By: _____

Action Code: **5 – M** Date: _____

Waiting Period – From: _____ To: _____

Benefits: -- From: _____ To: _____

Employee Returned to Work: _____ Estimated Return to Work Date: _____

Comments: _____

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