

**APPLICATION FOR DISABILITY LEAVE BENEFITS
EMPLOYER STATEMENT**

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 (DAS), Disability Services Unit, 30 E. Broad St, 27th Floor, Columbus, Ohio 43215. The agency may fax claims to DAS at (614)466-0831. **Please notify the Disability Unit when you learn of any unexpected return to work or other changes in the employee's status**

Employee Name		EMPLID	Date of Birth
Agency		Payroll #	
Job Title		CBU	
Date last worked	Number of hours worked that day		
Date disability occurred	Date application received		
Application received within 20 days of date last worked		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If no, 20 day filing date: _____			
Information for: <input type="checkbox"/> Initial application <input type="checkbox"/> Extension <input type="checkbox"/> Reinstatement <input type="checkbox"/> Part-time			
Date employee actually returned to work: _____			
One (1) year continuous service immediately prior to disability?		<input type="checkbox"/> Yes	<input type="checkbox"/> No*
Employee full-time?		<input type="checkbox"/> Yes	<input type="checkbox"/> No*
Part-time?		<input type="checkbox"/> Yes	<input type="checkbox"/> No*
If yes, give # of hours worked in 12 months preceding disability? _____			
Approved medical leave or FMLA		<input type="checkbox"/> Yes	<input type="checkbox"/> No*
Was the employee on administrative leave, childbirth/adoption or suspended?		<input type="checkbox"/> Yes*	<input type="checkbox"/> No
If yes, give dates: _____			
If suspension, give type: _____			
Did doctor or employee indicate claim is worked related?		<input type="checkbox"/> Yes*	<input type="checkbox"/> No
Did employee indicate working for wage/profit?		<input type="checkbox"/> Yes*	<input type="checkbox"/> No
Altered forms in any way?		<input type="checkbox"/> Yes*	<input type="checkbox"/> No
Forms signed by employee and doctor? If no, obtain signature.		<input type="checkbox"/> Yes	
Drug addiction or alcohol?		<input type="checkbox"/> Yes*	<input type="checkbox"/> No
Attempted Suicide or self inflicted?		<input type="checkbox"/> Yes*	<input type="checkbox"/> No
Allow employee to return to work on a part-time basis:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, part-time schedule: Hours: _____ Days: _____ Weeks: _____			
Allow employee to return to work in a Transitional Work Program:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, temporary modifications that can be made: _____			

Employee Name	EMPLID	Date of Birth
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Work-Related Claims:

Are you aware of other claims filed with BWC that may be related to this injury? Yes No
 If yes, provide information pertaining to the BWC claim and/or injury _____

Disciplinary Investigation:

Is the employee currently the subject of a disciplinary investigation? Yes No

If yes, provide answers to the following questions:

1. The date that the investigation was initiated _____
2. The basis of the investigation: _____
3. Why access to the employee is necessary for completion of the investigation _____

Agency comments: _____

Agency recommendation:

Approval Disapproval Doctor review

Reasons for disapproval or Doctor review: _____

Confirmation that employee's PD is included Yes

Agency contact: _____

Phone #: _____ **Fax #:** _____

E-mail address: _____

Appointing Authority or Designee signature: _____ **Date:** _____