

# Employee & Employer Instructions for completing the ADM 4726 Salary Continuation (SC) or Occupational Injury Leave (OIL) Extension / Reactivation Request Form

**This form must be completed as a part of the request for an extension or reactivation of your Salary Continuation (SC) or Occupational Injury Leave (OIL) benefits.**

Failure to fully complete this report may result in the denial or delay of benefits.

Write legibly with a pen (black or blue ink) - do not use pencil.

This form is to be used only when applying for an extension or reactivation of salary continuation or occupational injury leave benefits. If you are applying for the first time (initial application), please use form ADM 4303.

**YOU MUST SEEK MEDICAL TREATMENT FROM A WILMAPC APPROVED PROVIDER TO RECEIVE SALARY CONTINUATION OR OCCUPATIONAL INJURY LEAVE BENEFITS.**

**CONTACT YOUR MCO REPRESENTATIVE OR ACCESS THE PROVIDER LIST BELOW**

<http://www.das.ohio.gov/wilmapc>

**TO AVOID INTERRUPTION OR DELAY IN BENEFITS, PLEASE COMPLETE THE APPROPRIATE EMPLOYEE SECTIONS (ANSWERING ALL APPLICABLE QUESTIONS) AND RETURN TO YOUR HUMAN RESOURCES DEPARTMENT OR AS SOON AS YOU NEED TO EXTEND OR REACTIVATE BENEFITS.**

**Employee Section (page 1) – Please fully complete all of the requested information.**

- List your name, BWC claim #, date of injury and employee ID# or reference to your initial application.
- You must notify your supervisor of your absence and expected return to work date. Communication is essential.
- Answer all questions to document the progress of your condition.
- List the specific dates of disability you are requesting in this application.
- **Application must be filed with supporting medical documentation by way of a BWC Medco-14 form.**

**Employee Certification / Authorization**

Date and sign this report and return to your employing agency designee/benefits coordinator along with supporting medical documentation.

**Employer Section (page 2) – Please fully complete all of the requested information.**

The employer is responsible for completing the employer section

- The form must be completed within (5) working days of receipt of the completed employee portion and supporting medical documentation.

Date, sign this report and complete an ADM 4741 Calendar of Wages. Fax all documents to the Third Party Administrator (TPA) at (614) 764-1749.

**Forms needed for filing for an extension or reactivation of SC or OIL benefits:**

1. ADM 4726 SC or OIL Extension / Reactivation Request Form
2. ADM 4741 Calendar of Wages
3. BWC Medco-14 Physician's Report of Work Ability with TREATING DIAGNOSIS identified

# Salary Continuation or Occupational Injury Leave

## Extension / Reactivation Request

Employee Statement

BWC Claim #:

### Employee Section

Please read the instructions before completing the application.

Employee's name:

Date of injury:

Since your last request for benefits, has your condition:  
\_\_\_\_ Improved    \_\_\_\_ Stayed the same    \_\_\_\_ Worsened

What is the date of your next doctor's visit? \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
**You must seek medical treatment from a WILMAPC Provider**

Have you worked in any other job since the onset of your disability? \_\_\_\_ Yes    \_\_\_\_ No  
If yes, please explain:

**A BWC MEDCO-14 FORM MUST BE ATTACHED TO PROCESS THIS APPLICATION**  
**COMPLETE THE APPROPRIATE SECTIONS BELOW**

### I am requesting an EXTENSION of my benefits (complete this section)

I request an extension of:  
\_\_\_\_ Salary Continuation (SC)  
\_\_\_\_ Occupational Injury Leave (OIL)

For the dates below (mm/dd/yy):

From: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

To: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Total Hours requested: \_\_\_\_\_

Have you returned to work? \_\_\_\_ Yes    \_\_\_\_ No

If yes, please provide actual return to work date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Are you working full duty? \_\_\_\_ Yes    \_\_\_\_ No

Are you working in a transitional work assignment? \_\_\_\_ Yes    \_\_\_\_ No

If no, when do you expect your doctor will release you to return to work? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Have you discussed your agency's transitional work program with your doctor? \_\_\_\_ Yes    \_\_\_\_ No

### I am requesting REACTIVATION of my benefits (complete this section)

I request a reactivation of:  
\_\_\_\_ Salary Continuation (SC)  
\_\_\_\_ Occupational Injury Leave (OIL)

For the dates below (mm/dd/yy):

From: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

To: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date last worked: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

New period of disability began on: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Total Hours requested: \_\_\_\_\_

Reason for reactivation:

\_\_\_\_ Not progressing in transitional work program (TWP)

\_\_\_\_ TWP exhausted (reached the maximum time per policy)

\_\_\_\_ Surgery scheduled – date of surgery: \_\_\_\_\_

\_\_\_\_ Other: please explain:

If you have an additional allowance pending, it must be approved by BWC/IC prior to processing a reactivation for SC or OIL benefits.

Have you filed a C86 motion requesting an additional allowance?  
\_\_\_\_ Yes    \_\_\_\_ No

If yes, please list the condition(s): \_\_\_\_\_

### Employee Certification / Authorization

Pursuant to O.R.C. Sec. 2921.13, "No person shall knowingly make a false statement...with purpose to secure the payment of workers' compensation..." I am applying for recognition of my claim under the Ohio Workers' Compensation Act for work-related injuries that I did not purposefully 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 that attends to, treats or examines me to release all medical, psychological, and/or psychiatric information that is related to my workers' compensation claim to the Ohio Bureau of Workers' Compensation, the Ohio Industrial Commission, DAS, employing agency and their authorized representative(s). I understand that social security numbers are used to match individuals with other employment records that may be required in the processing of this claim and are used for informational purposes only. A photocopy of this authorization shall be as valid as the original.

Employee Signature

Date

# Salary Continuation or OIL Extension / Reactivation Request Employer Statement

PERSONNEL OFFICE USE ONLY

Date Employee Section Received in Office

## Employer Section

Please **read** the instructions before completing the application.

Employee's name:

BWC Claim #:

Date of Injury:

Employee ID #:

Employer name:

Employer BWC policy #:

### Employee is requesting to: (check all that apply)

\_\_\_\_\_ **EXTEND**

\_\_\_\_\_ **Salary Continuation benefits**

\_\_\_\_\_ **REACTIVATE**

\_\_\_\_\_ **Occupational Injury Leave benefits**

Total hours requested:

\_\_\_\_\_

Dates of Disability:

From: \_\_\_\_/\_\_\_\_/\_\_\_\_

To: \_\_\_\_/\_\_\_\_/\_\_\_\_

Breakdown of leave hours used (please attach a **Calendar of Wages**):

Sick Leave:\_\_\_\_\_ Vacation:\_\_\_\_\_ Personal Leave:\_\_\_\_\_

Comp Time:\_\_\_\_\_ LOA:\_\_\_\_\_

*Calendar of Wages is **NOT** required for part-time employees*

Has the employee returned to work? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please provide the actual date returned to work: \_\_\_\_/\_\_\_\_/\_\_\_\_

If no, please provide the estimated return to work date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Was a transitional work assignment \_\_\_\_\_ offered \_\_\_\_\_ under review?

Employer Remarks:

Employer Designee Signature

Date