Employee & Employer Instructions for completing the ADM 4726 Salary Continuation or Occupational Injury Leave Extension Request Form

This form must be completed as a part of the request for an extension 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 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 SEE A PHYSICIAN ON THE WILMAPC APPROVED PHYSICIAN LIST IN ORDER TO RECEIVE SALARY CONTINUATION OR OCCUPATIONAL INJURY LEAVE BENEFITS.

CONTACT YOUR MCO REPRESENTATIVE OR ACCESS THE PROVIDER LIST BELOW

http://www.das.ohio.gov/Divisions/CollectiveBargaining/Wilmapc/tabid/479/Default.aspx

TO AVOID INTERRUPTION OF BENEFITS, PLEASE COMPLETE THE EMPLOYEE SECTION IN ITS ENTIRETY (ANSWERING EVERY QUESTION) AND RETURN TO YOUR HUMAN RESOURCES OFFICE 48 HOURS PRIOR TO THE EXPIRATION OF PREVIOUSLY APPROVED BENEFITS

Employee Section

- 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 Medco14.**

Employee Certification / Authorization

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

Employer Section – 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 of SC or OIL benefits:

1. ADM 4726 Salary Continuation or Occupational Injury Leave Extension Request Form
2. ADM 4741 Calendar of Wages
3. BWC Medco14 Physician's Report of Work Ability with TREATING DIAGNOSIS identified

Salary Continuation or Occupational Injury Leave Extension Request

Employee and Employer Statement

PERSONNEL OFFICE USE ONLY
Date Employee Section Received in Office

Employee Section

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

Employee's name:	BWC Claim #:
Date of Injury:	Employee ID #:

Since your last request for benefits, has your condition:

_____ Improved _____ Stayed the same _____ Worsened

What is the date of your next doctor's visit? _____ / _____/ _____

I am requesting an extension of my benefits

_____**Salary Continuation** **or** _____**OIL**

for the dates below (mm/dd/yyyy):

From: _____ / _____ / _____

To: _____ / _____ / _____

Total Hours requested: _____

MEDCO 14

MUST BE ATTACHED TO PROCESS THIS APPLICATION

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

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:

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**

Employer Section

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

Employer name:	BWC Policy #:
Total hours requested:	Breakdown of hours requested (please attach a *Calendar of Wages):* Sick Leave:_____ Vacation:_____ Personal Leave:_____ Comp Time:_____ LOA:_____

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