

**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: <input type="checkbox"/> Yes <input type="checkbox"/> No* *If no, 20 Day Due 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: _____ Please notify DAS when employee returns to work. | |
| Is the employee currently the subject of a disciplinary investigation? <input type="checkbox"/> Yes* <input type="checkbox"/> 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? <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? _____ hours worked | |
| 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 suspension, give type: _____ | |
| If yes, give dates: _____ | |
| 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 | |
| *DECENTRALIZED AGENCIES—SEND TO DAS | |
| 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's Name: _____ DOB: _____

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: _____

