

State of Ohio Occupational Injury Leave Benefits Employee's Extension Request

PERSONNEL OFFICE USE ONLY
Date Employee's Statement Received in Office (Date Stamp Preferred)

Please read instructions on page 2 of this form before completing application

Section I - PERSONAL DATA

Employee's Name			Social Security Number	
Address	Street	City	State	Zip
Telephone	Home	Work	Date of Injury	Agency Payroll Number

Section II - HISTORY OF DISABLING CONDITION

Since your last application, has your condition: <input type="checkbox"/> Improved <input type="checkbox"/> Stayed the same <input type="checkbox"/> Worsened	Have you been hospitalized since your last application? <input type="checkbox"/> Yes, list dates _____ <input type="checkbox"/> No
If hospitalized, name hospital and their address: 	
Have you changed doctors since last application? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of new doctor:

Section III - RETURN TO WORK

Have you returned to work?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, provide the actual date you returned to work. _____	
Are you working your regular hours and duties or have these been modified while you complete your recovery?	<input type="checkbox"/> Regular Hours and/or Duties <input type="checkbox"/> Modified Hours and/or Duties
If no, when do you expect your doctor will release you to return to work? _____	
If your agency offers a Transitional Work Program, have you discussed this program with your doctor?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Have you been released for modified duty (If yes, give date)? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Have you worked in any other job since the onset of your disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you answered "yes" to any question, please explain: 	

Section IV - REQUEST FOR BENEFITS

I request benefits for (list dates mm/dd/yyyy)											
(1)	/	/	through	/	/	(3)	/	/	through	/	/
(2)	/	/	through	/	/	(4)	/	/	through	/	/

Section V - 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's Signature	Date
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INSTRUCTIONS FOR EMPLOYEE'S EXTENSION REQUEST

Occupational Injury Leave Benefits are authorized by ORC 124.381 and the bargaining unit contracts.

- * This form is to be used only when applying for an extension of Occupational Injury Leave benefits. If you are applying for the first time (initial application), use form ADM 4743.

Completion of Forms

- * Employee is responsible for completing Sections I through V of this application form.
- * Please print or type.
- * Employee should file extension application within twenty (20) days of the beginning of the period being requested.
- * All sections of application must be completed. Failure to fully complete application may result in delay or denial of benefits.

Section I - Personal Data

- * You must keep your agency notified of any change in your address.
- * You must notify your supervisor of your absence and your expected date for return to work.
- * List your date of injury for reference to your initial application.

Section II - History of Disabling Condition

- * Answer all questions to document the progress of your condition.
- * If you have been hospitalized since your last application or have changed physicians, complete question listed.
- * If you have changed physicians, attach a separate memo, explaining the reason you changed.

Section III - Return to Work

- * These questions must be answered to consider your application. Failure to answer these questions will result in a delay in processing.
- * If you returned to work, you must list the date you returned.
- * If your physician releases you for transitional or modified duty, you must contact your employer to determine if modified duty is available.
- * If you worked for any other employer during the period you are seeking Occupational Injury Leave for, you must report the employment to your agency designee within three (3) working days.

Section IV - Request for Benefits

- * List the specific dates of disability you are requesting in this application.
- * If any portion of the dates being requested were previously scheduled vacation, a suspension or other intervening non-disability caused absence, explain the occurrence.

Section V - Employee Certification/Authorization

- * Date and sign the form.
- * Obtain form ADM-4725 (Supplemental Physician's Statement) and take it to your physician. Upon completion of the supplemental physician's statement, deliver this application and the supplemental physician report to your agency designee.

Forms Needed for Filing for Extension of Benefits

ADM 4722	Employee's Extension Request
ADM 4725	Supplemental Physician's Statement
ADM 4726	Employer's Supplemental Report
ADM 4741	Calendar of Wages Paid Report