

**State of Ohio**  
**Occupational Injury Leave Benefits**  
**Appointing Authority Report**

Department of Administrative Services    Benefits  
Administration Services

*The employer shall, within five (5) days of receipt of the claim, complete this report and fax the form to  
CompManagement, DAS' Third Party Administrator at (614) 764-1749.*

*Instructions on back for completion of this form.*

<b>Please Complete All Questions</b>		<b>Check all that apply:</b>	
Employee's Name (Print or type)		<input type="checkbox"/> Fulltime Employee <input type="checkbox"/> AFSCME/OSCEA	
Agency Name	Payroll Number	<input type="checkbox"/> Part-time Employee <input type="checkbox"/> FOP Unit 2	
Employee's Classification	PCN Number	<input type="checkbox"/> Interim Employee <input type="checkbox"/> 1199	
		<input type="checkbox"/> Exempt <input type="checkbox"/> ORC 124.381	
		<input type="checkbox"/> Other <input type="checkbox"/> ORC 124.15	
		<input type="checkbox"/> OSTA	
<b>Employee History</b>			
Date/Time of injury	Date reported to agency	Date employee last worked	
Has employee returned to work?	If yes, give date of return	Number of hours being requested	
<b>Statement of Circumstances</b>			
<b>Complete Group 1 - All Claims (Except FOP Unit 2 and OSTA)</b>			
Was this injury sustained in the line of duty?	Yes ____	No ____	
Was the injury directly inflicted by a client, resident or inmate?	Yes ____	No ____	
Did injury result from accident or from misbehavior or negligence on the part of the employee? (If yes, explain below)	Yes ____	No ____	
<b>Complete Group 2 for FOP Unit 2 and OSTA</b>			
Was injury sustained while on duty?	Yes ____	No ____	
Was employee on meal or rest period or personal business, when injured?	Yes ____	No ____	
Was employee performing administrative/ clerical duties, when injured?	Yes ____	No ____	
Did injury result during performance of maintenance activities?	Yes ____	No ____	
<b>I RECOMMEND (check one): APPROVAL ____ DENIAL ____</b>			
Remarks:			
<b>Return to Work</b>			
Will you allow an employee with restrictions to return to work under a transitional work program?	Yes ____	No ____	
If employee can return to work with restrictions, will you allow them to work on a part-time basis?	Yes ____	No ____	
Will you make temporary modifications to the job requirements?	Yes ____	No ____	
Did you give the physician a position description so the employee's restrictions can be determined?	Yes ____	No ____	
Appointing Authority Signature	Date	Coordinator - Initials/ Date	

## INSTRUCTIONS FOR APPOINTING AUTHORITY REPORT

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

- \* This form is to be completed by the Appointing Authority or their designee. It must accompany form ADM 4743 (Application for Occupational Injury Leave - Employee Statement).

### **Completion of Forms**

- \* The employing agency is responsible for completion of all areas of this form.
- \* This form must be completed within five (5) work days after receipt of the completed application form (ADM 4743 and ADM 4721 (Attending Physician's Report)).
- \* Applications received by DAS which do not have a completed/signed Appointing Authority Report will not be processed.

### **Personal Data**

- \* The employee's name, agency name, the classification of the employee, the agency payroll number and the employee's PCN number must be shown.
- \* In the block at the top right, check the appropriate boxes to identify whether the employee is fulltime or part-time. Additionally, indicate ORC or contract this report covers.

### **Employee History**

- \* Indicate the date the injury occurred and when it was reported to the employer.
- \* List the last day employee worked and if the employee has returned to work (if yes, give the date of return).
- \* List the number of hours being requested for the period of disability indicated.

### **Return to Work**

- \* All Revised Code and contract authorities require that the Appointing Authority answer conclusively the questions listed.

**Group 1** - This group of questions must be answered for all claims, except FOP Unit 2 and OSTA.

**Group 2** - This group of questions must be answered if the employee is covered by FOP Unit 2 or OSTA pursuant to ORC 124.15.

### **Appointing Authority Recommendations**

- \* If you recommend approval, no further statement is necessary.
- \* If you are recommending disapproval, please indicate in the "Remarks" area the basis for this recommendation.
- \* Attach all supporting documentation for your recommendation.

### **Return to Work**

- \* These questions must be answered and will be used to evaluate benefits. Should you make work available to an employee, within their physical capabilities, benefits may be denied if that job offer is declined.

### **Signature**

- \* Appointing authority reports will not be deemed as complete unless signed by the actual appointing authority (or their designee).
- \* Date of signature is required
- \* The "Coordinator - Initials / Date" box is for those agencies utilizing a central office coordinator review.