

State of Ohio

Occupational Injury Leave Benefits

Supplemental Employer Statement

Department of Administrative Services
Benefits Administration Services

The employer shall, within five (5) days of receipt of Employee Extension request, complete this report and fax the forms

to CompManagement, DAS' Third Party Administrator, at (614) 764-1749

Instructions for completion are on page 2 of this form.

Please Complete All Questions		Check all that apply:	
Employee's Name (Print or type)		<input type="checkbox"/> Full-time Employee	<input type="checkbox"/> AFSCME/OSCEA
Date of Injury	Payroll Number	<input type="checkbox"/> Part-time Employee	<input type="checkbox"/> FOP Unit 2
Agency Name		<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(D)
			<input type="checkbox"/> OSTA
Claim - History			
Previous Benefits Approved (mm/dd/yyyy):			
/	/	to	/ / = hours
/	/	to	/ / = hours
/	/	to	/ / = hours
		Total hours used to date =	hours as of / /
This Request			
Employee requesting (mm/dd/yyyy):			
/	/	to	/ / for hours
/	/	to	/ / for hours
Total hours this request	Breakdown of hours requested (please attach a <i>Calendar of Wages</i>):		
	Sick leave:	Vacation:	Personal leave: Comp Time: LOA:
Return to Work			
Has the employee returned to work?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, list date:		_____	
If no, what is the estimated return to work date?		_____	
Do you have a Transitional Work Program?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, have you discussed TWP with the employee or their doctor?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Will you make temporary modifications to job requirements?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is part-time work available?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Employer Remarks			
_____ Medical review of this request is recommended			
_____ An Independent Medical Exam is requested			
Agency Designee Signature	Date	Coordinator - Initials/ Date	

INSTRUCTIONS FOR SUPPLEMENTAL EMPLOYER STATEMENT

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

- * This form is to be completed by the employer and is to accompany the employee's request for extension of benefits (ADM 4722) and the supplemental physician's statement (ADM 4725).
- * This form shall accompany only requests for extension of benefits

Completion of Forms

- * The employer is responsible for completion of all areas of this form.
- * This form must be completed within five (5) working days of receipt of the completed employee application and medical report(s) for extension.
- * All forms are to be faxed to CompManagement at 614-764-1749.

Personal Data

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

Claim History

- * List all dates previously approved OIL for this date of injury and the number of hours for each approval.
- * Show total hours approved previously.

This Request

- * List the dates of disability being requested by employee for current application.
- * List types of leave this request represents.

Return to Work

- * If your employee has returned to work, give date.
- * If you have a transitional work program, or are willing to make temporary modifications, indicate in appropriate area.

Employer Remarks

- * The agency is encouraged to provide any additional information that may assist in determining approval of additional benefits.
- * If employer recommends medical review (by DAS) or is requesting an independent medical examination, check appropriate box.
- * The employer (appointing authority) or their designee may sign this form and date signature.
- * Those agencies utilizing central office review by coordinators should require that coordinator initial form.