APPLICATION FOR DISABILITY LEAVE BENEFITS EMPLOYER STATEMENT

The employer shall within five (5) days of receipt of the claim forward the claim and the claim recommendation to the Ohio Department of Administrative Services (DAS), Disability Services Unit, 30 E. Broad St, 27th Floor, Columbus, Ohio 43215. The agency may email claims to *DAS.Disability@das.ohio.gov*. Fax number: 1-614-466-0831. **Please notify the Disability Unit when you learn of any unexpected return to work or other changes in the employee's status.**

Employee Name	State of Ohio User ID	Date of Birth
Agency	Payroll#	
Job Title	CBU	
Date Last Worked	Number of Hours Worked that Day	
Date Disability Occurred	Date Application Received	

Application received within 20 days of date last worked ☐ Yes ☐ No
If no, 20 day filing date:

Information for: ☐ **Initial Application** ☐ **Extension** ☐ **Reinstatement**

Date employee **actually** returned to work:	_____
One (1) year continuous service **immediately** prior to disability?	☐ Yes ☐ No*
Employee full time?	☐ Yes ☐ No*
Part time?	☐ Yes ☐ No*
If yes, give number of hours **worked** in 12 months preceding disability?	_____
Approved medical leave or FMLA	☐ Yes ☐ No*
Surgery performed?	☐ Yes* ☐ No
If yes, date confirmed and contact name:	_____
Was the employee on administrative leave, childbirth/adoption or suspended?	☐ Yes ☐ No*
If yes, give dates:	_____
If suspension, give type:	_____
Did doctor or employee indicate claim is worked related?	☐ Yes* ☐ No
Did employee indicate working for wage/profit?	☐ Yes* ☐ No
Altered forms in any way?	☐ Yes* ☐ No
Forms signed by employee and doctor? If no, obtain signature.	☐ Yes ☐ No
Drug addiction or alcohol?	☐ Yes* ☐ No
Attempted suicide or self-inflicted?	☐ Yes* ☐ No
Allow employee to return to work on a part-time basis:	☐ Yes ☐ No*
If yes, part-time schedule: Hours _____ Days _____ Weeks _____	
Allow employee to return to work in a Transitional Work Program:	☐ Yes ☐ No
If yes, temporary modifications that can be made: _____	
_____	

Employee Name	State of Ohio User ID	Date of Birth

Work-Related Claims:

Are you aware of other claims filed with BWC that may be related to this injury? ☐ Yes ☐ No

If yes, provide information pertaining to the BWC claim and/or injury _____

_____

_____

_____

_____

Disciplinary Investigation:

Is the employee currently the subject of a disciplinary investigation? ☐ Yes ☐ No

If yes, provide answers to the following questions:

1. The date that the investigation was initiated _____

2. The basis of the investigation: _____

_____

3. Why access to the employee is necessary for completion of the investigation _____

_____

_____

_____

_____

Agency Comments: _____

_____

_____

_____

_____

_____

_____

Agency Recommendation: ☐ Approval ☐ Disapproval ☐ Doctor review

Reasons for disapproval or doctor review: _____

_____

_____

_____

_____

Confirmation that employee's PD is included ☐ Yes

Agency Contact: _____

Phone #: _____ **Fax #:** _____

Email Address: _____

Appointing Authority or Designess Signature: _____

Date: _____