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.

<table>
<thead>
<tr>
<th>Employee Name</th>
<th>State of Ohio User ID</th>
<th>Date of Birth</th>
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<thead>
<tr>
<th>Agency</th>
<th>Payroll#</th>
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<thead>
<tr>
<th>Job Title</th>
<th>CBU</th>
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<thead>
<tr>
<th>Date Last Worked</th>
<th>Number of Hours Worked that Day</th>
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<tr>
<th>Date Disability Occurred</th>
<th>Date Application Received</th>
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Application received within 20 days of date last worked  
If no, 20 day filing date:  
☐ Yes  ☐ No

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?  
☐ Yes  ☐ No*

Approved medical leave or FMLA  
☐ Yes  ☐ No*

Surgery performed?  
☐ Yes*  ☐ No

If yes, date confirmed and contact name:  
☐ Yes  ☐ No*

Was the employee on administrative leave, childbirth/adoption or suspended?  
☐ Yes  ☐ No*

If yes, give dates:  
☐ Yes  ☐ No*

If suspension, give type:  
☐ Yes*  ☐ No

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 _____  
☐ Yes  ☐ No

Allow employee to return to work in a Transitional Work Program:  
☐ Yes  ☐ No

If yes, temporary modifications that can be made:  
__________________________________________
### 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:  