Employee & Employer Instructions for completing the ADM 4726 Salary Continuation (SC) or Occupational Injury Leave (OIL) Extension / Reactivation Request Form

This form must be completed as a part of the request for an extension or reactivation of your Salary Continuation (SC) or Occupational Injury Leave (OIL) benefits.

Failure to fully complete this report may result in the denial or delay of benefits.

Write legibly with a pen (black or blue ink) - do not use pencil.

This form is to be used only when applying for an extension or reactivation of salary continuation or occupational injury leave benefits. If you are applying for the first time (initial application), please use form ADM 4303.

YOU MUST SEEK MEDICAL TREATMENT FROM A WILMAPC APPROVED PROVIDER TO RECEIVE SALARY CONTINUATION OR OCCUPATIONAL INJURY LEAVE BENEFITS.

CONTACT YOUR MCO REPRESENTATIVE OR ACCESS THE PROVIDER LIST BELOW

http://www.das.ohio.gov/wilmapc

TO AVOID INTERRUPTION OR DELAY IN BENEFITS, PLEASE COMPLETE THE APPROPRIATE EMPLOYEE SECTIONS (ANSWERING ALL APPLICABLE QUESTIONS) AND RETURN TO YOUR HUMAN RESOURCES DEPARTMENT AS SOON AS YOU NEED TO EXTEND OR REACTIVATE BENEFITS.

Employee Section (page 1) – Please fully complete all of the requested information.

- List your name, BWC claim #, and date of injury
- You must notify your supervisor of your absence and expected return to work date. Communication is essential.
- Answer all questions to document the progress of your condition.
- List the specific dates of benefits you are requesting.
- **This form must be filed with supporting medical documentation, e.g. BWC Medco-14 form.**

Employee Certification / Authorization

Date and sign this report and return to your employing agency designee/benefits coordinator along with supporting medical documentation.

Employer Section (page 2) – Please fully complete all of the requested information.

The employer is responsible for completing the employer section

- The form must be completed within (5) working days of receipt of the completed employee portion and supporting medical documentation.

Date, sign this report and complete an ADM 4741 Calendar of Wages. Fax all documents to the Third Party Administrator (TPA) at (614) 764-1749.

Forms needed for filing for an extension or reactivation of SC or OIL benefits:

1. ADM 4726 SC or OIL Extension / Reactivation Request Form
2. ADM 4741 Calendar of Wages
3. BWC Medco-14 Physician's Report of Work Ability with TREATING DIAGNOSIS identified

Salary Continuation or Occupational Injury Leave Extension / Reactivation Request

Employee Statement

BWC Claim #:

Employee Section	Please **read** the instructions before completing the application.
Employee's name:	Date of injury:
Since your last request for benefits, has your condition: _____ Improved _____ Stayed the same _____ Worsened	What is the date of your next doctor's visit? _____ / _____/ _____ You must seek medical treatment from a WILMAPC Provider

Have you worked in any other job since the onset of your disability? _____ Yes _____ No
If yes, please explain:

A BWC MEDCO-14 FORM MUST BE ATTACHED TO PROCESS THIS FORM

COMPLETE THE APPROPRIATE SECTIONS BELOW

❑ I am requesting an EXTENSION of my benefits (complete this section)

I request an extension of:
_____**Salary Continuation (SC)**
_____**Occupational Injury Leave (OIL)**

For the dates below (mm/dd/yy):

From: _____ / _____ / _____

To: _____ / _____ / _____

Total Hours requested: _____

Have you returned to work? _____ Yes _____ No

If yes, please provide actual return to work date _____ / _____/ _____

Are you working full duty? _____ Yes _____ No

Are you working in a transitional work assignment? _____ Yes _____ No

If no, when do you expect your doctor will release you to return to work? _____/_____/_____

Have you discussed your agency's transitional work program with your doctor? _____ Yes _____ No

❑ I am requesting REACTIVATION of my benefits (complete this section)

I request a reactivation of:
_____ **Salary Continuation (SC)**
_____ **Occupational Injury Leave (OIL)**

For the dates below (mm/dd/yy):

From: _____ / _____ / _____

To: _____ / _____ / _____

Date last worked: _____ / _____ / _____

New period of disability began on: ____/____/_____

Total Hours requested: _____

Reason for reactivation:
_____ Not progressing in transitional work program (TWP)

_____ TWP exhausted (reached the maximum time per policy)

_____ Surgery scheduled – date of surgery: _____

_____ Other: please explain:_____

If you have an additional allowance pending, it must be approved by BWC/IC **prior** to processing a reactivation for SC or OIL benefits.

Have you filed a C86 motion requesting an additional allowance?
_____ Yes _____ No

If yes, please list the condition(s): _____

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 Signature	**Date**

Salary Continuation or OIL Extension / Reactivation Request

Employer Statement

PERSONNEL OFFICE USE ONLY
Date Employee Section Received in Office

Employer Section	Please **read** the instructions before completing the application.
Employee's name:	BWC Claim #:
Date of Injury:	Employee ID #:
Employer name:	Employer BWC policy #:

Employee is requesting to: **(check all that apply)**

_____ **EXTEND** _____ **Salary Continuation benefits**

_____ **REACTIVATE** _____ **Occupational Injury Leave benefits**

Total hours requested:

_____

Dates of Disability:

From: _____/_____/_____

To: _____/_____/_____

Breakdown of leave hours used (please attach a ***Calendar of Wages***):

Sick Leave:_____ Vacation:_____ Personal Leave:_____

Comp Time:_____ LOA:_____

*Calendar of Wages is **NOT** required for part-time employees*

Has the employee returned to work? _____ Yes _____ No

If yes, please provide the actual date returned to work: _____/_____/_____

If no, please provide the estimated return to work date: _____/_____/_____

Was a transitional work assignment _____ offered _____ under review?

Employer Remarks:

Employer Designee Signature	Date