***DISABILITY SUPPLEMENTAL INFORMATION***
***AGENCY COVERSHEET***

Employee's Name: _____

Claim Number: _____ State of Ohio User ID _____

Agency: _____ Payroll #: _____

Information is for:

- ❒ Return to work
  Date employee ***ACTUALLY*** returned to work: _____
- ❒ Extension
- ❒ Reinstatement ***NEW*** date last worked: _____
- ❒ Part-time Part-time schedule:
  hours per day: _____
  days per week: _____

Allow light/modified duty or Transitional Work Program (TWP) ❒ yes ❒ no

***If yes, describe modifications that can be made or attach documentation of TWP agreement:***

_____

_____

_____

**Agency Recommendation:** ❒ **Approval** ❒ **Disapproval** ❒ **Dr. Review** ***(send PD)***

Reason for disapproval or Dr. review: _____

_____

_____

Additional information or comments: _____

_____

_____

Agency contact: _____ Phone #: _____

E-mail: _____ Fax #: _____

_____ _____

Appointing Authority or Designee Signature Date: