**APPLICATION FOR DISABILITY LEAVE BENEFITS**

**EMPLOYER STATEMENT**

**INITIAL/SUPPLEMENTAL DISABILITY WORKSHEET**

The employer shall within five (5) days of receipt of the claim forward the claim and the claim recommendation to the Department of Administrative Services, Disability Section, 30 E. Broad Street, 28th Floor, Columbus, Ohio 43215. Please notify the Disability Section when you learn of any unexpected return to work or other changes in employee’s status.

<table>
<thead>
<tr>
<th>Employee Name:</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency:</td>
<td>Payroll #:</td>
</tr>
<tr>
<td>Job Title:</td>
<td>CBU:</td>
</tr>
<tr>
<td>Date Last Worked:</td>
<td>Date Disability Occurred:</td>
</tr>
<tr>
<td>Date Received:</td>
<td>Received w/in 20 Days of Date Last Worked: □ Yes □ No*</td>
</tr>
</tbody>
</table>

*If no, 20 Day Due Date:

<table>
<thead>
<tr>
<th>Information for:</th>
<th>□ Initial application</th>
<th>□ Extension</th>
<th>□ Reinstatement</th>
<th>□ Part-time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date employee actually returned to work:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Is the employee currently subject of a disciplinary investigation?** □ Yes* □ No

  **If yes, provide answers to the following questions in the comments section on page 2:**
  1. The date that the investigation was initiated;
  2. The basis of the investigation; and
  3. Why access to the employee is necessary for completion of the investigation

- **One (1) year continuous service immediately prior to disability?** □ Yes □ No*

- **Employee full-time?** □ Yes □ No

- **Part-time?** □ Yes □ No*

  **If yes, give # of hours worked in 12 months preceding disability?**

  __________ hours worked

- **Approved medical leave or FMLA** □ Yes □ No*

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

  **If suspension, give type:** __________________________________________

  **If yes, give dates:** _______________________________________________

- **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

- **Drug addiction or alcohol?** □ Yes* □ No

- **Suicide or self inflicted?** □ Yes* □ No

*DECENTRALIZED AGENCIES—SEND TO DAS

- **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's Name: ________________________________________________  SS #: ______________________________________________

**Agency Recommendation:**  
- [ ] Approval  
- [ ] Disapproval  
- [ ] Dr. Review (send PD)

Reasons for disapproval or Dr. review: 
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

**Work-Related Claims:**  
Are you aware of other claims filed with BWC that may be related to this injury?  
- [ ] Yes  
- [ ] No

**Agency Comments:**  
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

**Agency Contact:** ______________________________________  **Phone #:** ____________________  
**Fax #:** ____________________  **E-mail address:** ______________________________________

(Appointing Authority or Designee Signature)  
(Date)

---

**Complete this section only if processing claims through Decentralization**

Claim #:  
Diagnosis:

Disability Code:  
Standard Recovery Period in Weeks:  
Processed By:

Action Code: 5 – M  
Date: ____________________________

Waiting Period – From: ____________________________  To: ____________________________

Benefits: -- From: ____________________________  To: ____________________________

Employee Returned to Work: ____________________________  Estimated Return to Work Date: ____________________________

Comments: ______________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________