

Employee & Employer Instructions for completing the ADM 4726 Salary Continuation or Occupational Injury Leave Extension Request Form

This form must be completed as a part of the request for an extension 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 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 SEE A PHYSICIAN ON THE WILMAPC APPROVED PHYSICIAN LIST IN ORDER TO RECEIVE SALARY CONTINUATION OR OCCUPATIONAL INJURY LEAVE BENEFITS.

CONTACT YOUR MCO REPRESENTATIVE OR ACCESS THE PROVIDER LIST BELOW

<http://www.das.ohio.gov/Divisions/CollectiveBargaining/Wilmapc/tabid/479/Default.aspx>

TO AVOID INTERRUPTION OF BENEFITS, PLEASE COMPLETE THE EMPLOYEE SECTION IN ITS ENTIRETY (ANSWERING EVERY QUESTION) AND RETURN TO YOUR HUMAN RESOURCES OFFICE 48 HOURS PRIOR TO THE EXPIRATION OF PREVIOUSLY APPROVED BENEFITS

Employee Section

- List your name, BWC claim #, date of injury and employee ID# or reference to your initial application.
- 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 disability you are requesting in this application.
- **Application must be filed with supporting medical documentation by way of Medco14.**

Employee Certification / Authorization

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

Employer Section – 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 of SC or OIL benefits:

1. ADM 4726 Salary Continuation or Occupational Injury Leave Extension Request Form
2. ADM 4741 Calendar of Wages
3. BWC Medco14 Physician's Report of Work Ability with TREATING DIAGNOSIS identified

Salary Continuation or Occupational Injury Leave Extension Request

Employee and Employer Statement

PERSONNEL OFFICE USE ONLY
Date Employee Section Received in Office

Employee Section		Please read the instructions before completing the application.	
Employee's name:		BWC Claim #:	
Date of Injury:		Employee ID #:	
Since your last request for benefits, has your condition: <input type="checkbox"/> Improved <input type="checkbox"/> Stayed the same <input type="checkbox"/> Worsened		What is the date of your next doctor's visit? ____ / ____ / ____	
I am requesting an extension of my benefits <input type="checkbox"/> Salary Continuation or <input type="checkbox"/> OIL for the dates below (mm/dd/yyyy): From: ____ / ____ / ____ To: ____ / ____ / ____ Total Hours requested: _____		Have you returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide actual return to work date ____ / ____ / ____ Are you working full duty? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you working in a transitional work assignment? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Must seek medical treatment from a WILMAPC provider	
MEDCO 14 MUST BE ATTACHED TO PROCESS THIS APPLICATION			
Have you worked in any other job since the onset of your disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:			

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
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Employer Section		Please read the instructions before completing the application.	
Employer name:		BWC Policy #:	
Total hours requested:	Breakdown of hours requested (please attach a <i>Calendar of Wages</i>): Sick Leave: ____ Vacation: ____ Personal Leave: ____ Comp Time: ____ LOA: ____		
Has the employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> offered <input type="checkbox"/> under review?			
Employer Remarks:			
Employer Designee Signature		Date	

Employee and Employer Instructions for completing the SC (Salary Continuation) or OIL (Occupational Injury Leave) Hourly Payment Request Form

A full-time permanent employee on a transitional work assignment equivalent to his/her regularly scheduled hours and who has continuing treatment related to his/her Workers' Compensation claim must first attempt to schedule the appointment during non-working hours. Second, if the employee is unable to schedule the appointment during non-working hours, the employee must work with the employer to flex his/her schedule to accommodate the appointment. After these two (2) options have been exhausted, the employee may use any remaining salary continuation or OIL hours to attend the appointment, not to exceed one (1) hour per appointment, with a maximum of three (3) appointments per week.

Employee Section – Complete in its entirety

The injured employee is responsible for completing the employee section

The employee should check both options to be eligible to request this payment

- 1) attempted to schedule my appointment during non-working hours and;
- 2) worked with my employer to flex my schedule to accommodate the appointment

The employee should take the form to his/her medical appointment and ask the provider to complete the medical provider's section.

Once the provider's section is complete and the employee returns to work from his/her appointment, this form should be submitted to the agency Workers' Compensation benefits coordinator.

WILMAPC PROVIDER

**IN ORDER TO RECEIVE SALARY CONTINUATION OR OCCUPATIONAL INJURY LEAVE,
YOU MUST SEEK MEDICAL TREATMENT FROM A PHYSICIAN ON THE WILMAPC
APPROVED PHYSICIAN LIST IF YOU ARE INJURED ON THE JOB AND QUALIFY.**

**YOU MAY CONTACT YOUR MCO REPRESENTATIVE OR ACCESS THE WILMAPC PROVIDER LIST
BY THE WEBSITE BELOW:**

**[http://www.das.ohio.gov/Divisions/CollectiveBargaining/Wilmapc/tabid/479/
Default.aspx](http://www.das.ohio.gov/Divisions/CollectiveBargaining/Wilmapc/tabid/479/Default.aspx)**

Medical Provider Section – Complete in its entirety

The employee's medical provider needs to verify that the employee was actually seen in his/her office on the requested date.

Employer Section – Complete in its entirety

The employer is responsible for completing the employer section.

The employer may contact the employee's physician to verify that the employee attempted to schedule the initial appointment during non-working hours.

Once the form is complete, fax to the Third Party Administrator at **(614) 764-1749**.

SC or OIL Hourly Payment Request Form

Employee and Employer Statement

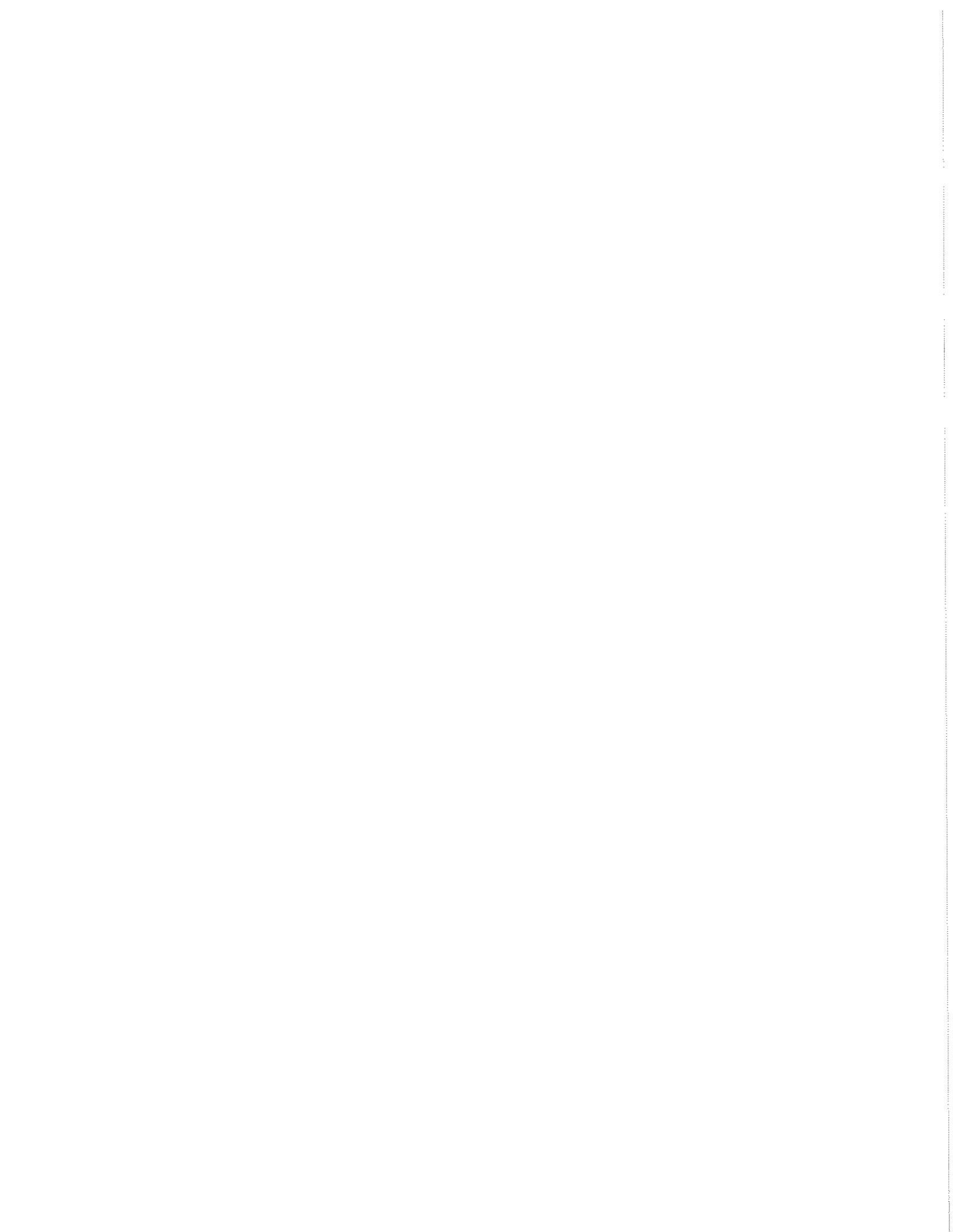
Please read the instructions before completing the application

OFFICE USE ONLY
Date Received in Office

Employee Section	
Employee's name:	BWC Claim #:
Date of Injury:	Employee ID #:
Name of provider (please print):	Provider phone #:
<p>I am a full-time permanent employee on a transitional work assignment equivalent to my regularly scheduled hours and am continuing to seek treatment related to my workers' compensation claim.</p> <p>I am requesting ONE HOUR of: _____ Salary Continuation or _____ Occupational Injury Leave to attend a medical appointment on: Date: _____ From: _____ am/pm To: _____ am/pm</p> <p>In order to be eligible to receive payment in an increment of one hour, I have; _____ attempted to schedule my appointment during non-working hours and; _____ worked with my employer to flex my schedule to accommodate the appointment</p> <p>I understand that if I have not explored the above two options, I am not eligible to receive payment for my medical appointment.</p>	
Employee Signature:	Date:

Medical Provider Section	Must be a WILMAPC Provider
Office Stamp:	OR: Name: _____ Address: _____ City, State & Zip: _____ Telephone Number: _____
I verify that the above named injured worker was seen in this office on _____ (DATE) at _____ (TIME)	
Provider Signature:	Date:

Employer Section	
Employer name:	BWC Policy #:
<p>Is the employee participating in a transitional work assignment and working regularly scheduled hours? _____ Yes _____ No</p> <p>Has the employee attempted to schedule his/her appointment during non working hours? _____ Yes _____ No</p> <p>Has the employee worked with the employer in attempt to flex his/her schedule to accommodate the appointment? _____ Yes _____ No</p>	
Employer recommends: _____ Approval _____ Denial	
Comments:	
Employer Designee Signature:	Date:



Employee Instructions for completing the ADM 4303 Injury / Illness Report

This form **must be completed** as part of the Workers' Compensation application process. Failure to fully complete this report may result in the denial or delay of benefits. Write legibly with a black or blue ink pen (do not use pencil) or file electronically.

Employee Statement

The injured employee is responsible for completing the following sections:

Personal Information- Please fully complete all requested information.

Incident report Information

You must notify your supervisor immediately (within 24 hours) after any accident or onset of illness.

- Follow your specific agency's accident procedures
- Provide the exact date and time the accident occurred
- Provide the exact date and time the incident was reported
- List to whom (name, title and phone #) you reported the incident

Off Work Benefits – you must make a selection, refer to your specific bargaining unit contract for details. *You cannot collect both temporary total compensation and salary continuation or OIL benefits at the same time.*

- **Temporary Total Compensation (TT)** – TT benefits are paid by BWC. Your injury must result in eight (8) or more calendar days of lost time from work before TT is considered. Please refer to www.ohiobwc.com for specific details
- ***** Salary Continuation (SC)** – SC is equal to the employee's total rate of pay not to exceed 480 hours per workers' compensation claim and paid by the employer. SC is effective the date of the injury and does not require a waiting period.
- ***** Occupational Injury Leave (OIL)** – An employee who incurs a work-related injury or illness inflicted by a ward of the State may be entitled to OIL. OIL is equal to the employee's total rate of pay not to exceed 960 hours per workers' compensation claim and paid by the employer. Refer to your specific bargaining unit contract for details, as OIL applies to certain agencies.

WILMAPC PROVIDER

***** IN ORDER TO RECEIVE SALARY CONTINUATION OR OCCUPATIONAL INJURY LEAVE, YOU MUST SEEK MEDICAL TREATMENT FROM A PHYSICIAN ON THE WILMAPC APPROVED PHYSICIAN LIST IF YOU ARE INJURED ON THE JOB AND QUALIFY.**

YOU MAY ACCESS THE WILMAPC PROVIDER LIST OR CONTACT YOUR MCO REPRESENTATIVE

<http://www.das.ohio.gov/Divisions/CollectiveBargaining/Wilmapc/tabid/479/Default.aspx>

Employee Accident Description

You must explain in DETAIL how you were injured, including

- What caused injury/illness, where the accident occurred, how the accident occurred, explain what you were doing at the time of the accident, include the ACTUAL SPECIFIC location where the incident occurred and list any witnesses to the incident

Nature of Injury/Illness

Indicate the body part affected and the illness or injury that resulted from the incident. Include details of any medical attention sought or that you plan to seek.

- Did you seek on-site medical treatment? Check yes or no. If yes, provide details of treatment rendered in "nature of Injury/Illness" section.
- Be sure to indicate name of outside medical provider

Injured Worker Signature/Date

Please read and complete this form in its entirety. Be sure to date and sign it before returning it to your employing agency designee/personnel officer.

NOTICE: "The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information", as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."



Injury / Illness Report

Employee Statement (completed by employee)

Check all that apply:

- Full time Employee
- Part-time Employee
- Interim Employee
- Exempt
- Seasonal / temp
- Other: _____

- OCSEA
Unit _____
- FOP Unit 2
- 1199
- ORC 124.381
- ORC 124.15
- OSTA
- Other: _____

PERSONAL INFORMATION

Employee's name:

Address (Street / City / State / Zip):

Social Security #:

Phone # (Home / Work):

Date of Birth:

Age:

Sex:

Your employer's name:

Job Title:

Employer's BWC Policy #:

Regular work hours: From _____ am/pm To _____ am/pm

Work Days: ___Sun ___Mon ___Tues ___Weds ___Thurs ___Fri ___Sat

INCIDENT REPORT INFORMATION

Date/Time of Injury:

Were you working overtime when this injury occurred? ___ Yes ___ No

Reported to (Name/Title):

Date/Time Reported:

OFF WORK BENEFITS:

Check one benefit type:

- Temporary Total Compensation
- Salary Continuation*
- Occupational Injury Leave*; inflicted by a ward of the State (inmate, patient, resident, client, youth or student)

***Must seek medical treatment from WILMAPC**

Exact location of incident (Include name of building/area and location within building/area or town, county, State Route or mile marker):

Were there any witnesses? Please list names:

Are you working, in any capacity, for another employer: ___ Yes ___ No If yes, employer name:

EMPLOYEE ACCIDENT DESCRIPTION (Please DESCRIBE how the injury happened in DETAIL)

What duties were you performing?

What caused the injury? (e.g. I slipped on the ice.)

NATURE OF ILLNESS/INJURY (PLEASE BE VERY SPECIFIC)

Indicate body part(s) affected:

Describe the illness or injury resulting from the incident:

On-site medical treatment sought/rendered? ___ Yes ___ No

If yes, from?

Clinician observation / assessment:

Clinician initials: _____

Outside medical treatment sought/rendered? ___ Yes ___ No (If yes, provide the name and phone number of medical provider below)

Physician's name & phone #:

Benefit application/medical release – I am applying for a claim under the Ohio Workers' Compensation Act for work-related injuries that I did not purposely inflict. I affirm that I elect to receive benefits under the Ohio workers' compensation laws for my claim, and I waive and release my right to file for and receive compensation and benefits under the laws of any other state for this claim. I request payment for compensation and/or medical benefits as allowable, and authorize direct payment to my medical providers. I permit and authorize any provider who attends, treats or examines me, and the Ohio Rehabilitation Services Commission (where relevant) to release medical, psychological, psychiatric, vocational or social information that is causally or historically related to my physical or mental injuries relevant to issues necessary for the administration of my claim to: BWC, the Industrial Commission of Ohio, DAS, employing agency, the employer's BWC MCO and their authorized representatives. 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



Injury / Illness Report

Employer Statement *(completed by WC designee)*

Date received by personnel:

EMPLOYER INFORMATION		BWC Claim # and/or injury date:
Employee's Name:		BWC Policy #:
Agency (Specify operating location or Central Office):		Work County:
Address (Street / City / State / Zip):		
Hire date:	Employment type: <input type="checkbox"/> PT <input type="checkbox"/> FT <input type="checkbox"/> Interim <input type="checkbox"/> Temp	
Bargaining Unit Status: OCSEA Unit _____ FOP _____ 1199 _____ Exempt _____ Other: _____		
Did employee seek nursing/first aid care? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, from?
Employee has applied for payment under: <input type="checkbox"/> Salary Continuation <input type="checkbox"/> OIL <input type="checkbox"/> WC-TTD <input type="checkbox"/> Disability Other: _____		
Was employee off work seven (7) consecutive days? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Did employee use sick leave, vacation leave, personal leave, or any other leave with pay for any of the lost work days? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, have you attached a calendar of wages showing leave usage? <input type="checkbox"/> Yes <input type="checkbox"/> No		
What was the last date the employee worked? DATE _____	Has the employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If YES, give ACTUAL date:	If NO, give estimated RTW date:
Was a Transitional Work Assignment offered to this employee? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is a Position Description and / or Job Analysis attached? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Did this injury result in a fatality? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, give date of death:
Date faxed/called in to MCO:		By whom:
SC or OIL BENEFITS: (Check if applicable) A completed calendar of wages must be submitted if SC or OIL is requested		
<input type="checkbox"/> SALARY CONTINUATION <input type="checkbox"/> OCCUPATIONAL INJURY LEAVE		OIL - Do you believe this is a legitimate OIL injury? <input type="checkbox"/> Yes <input type="checkbox"/> No Appointing Authority Signature: _____ Date: _____ Coordinator's initials: _____
Date employee became disabled:		Comments:
Total hours being requested:		
Treating with an approved WILMAPC physician? <input type="checkbox"/> Yes <input type="checkbox"/> No		
EMPLOYER CLAIM CONTACT (please print clearly)		
Name	Title	Phone #
EMPLOYER CLAIM POSITION (check applicable section)		
<input type="checkbox"/> CERTIFICATION Based on the information known at this time the employer CERTIFIES that the facts in this application are correct and valid. This certification does not waive any appeal rights that may exist if the employer so chooses to exercise those rights.	<input type="checkbox"/> UNKNOWN This claim is still in process and pending further investigation and claim research.	<input type="checkbox"/> REJECTION The employer rejects the claim for the following reason(s):
Employer signature		Date



Injury / Illness Report

Supplemental Statement (completed by Supervisor and Safety & Health Coordinator)

Employee Name: _____

BWC Claim #: _____

Supervisor Statement (to be completed by the Supervisor)

Date Injury reported to supervisor:		Time Injury reported to supervisor:	
Contributing weather or environmental factors:		Any equipment involved? ____ Yes ____ No	
		If yes, please specify:	
Was the employee performing his/her regular job duties? ____ Yes ____ No			
If No, please explain:			
Specific action taken to avoid another injury:			
Will disciplinary action be initiated? ____ Yes ____ No			
Please explain:			
Supervisor full name:		Work phone #:	
Job title:	Regular shift:	Days off:	
Supervisor's signature:		Date:	

Safety & Health Statement (to be completed by the S&H Coordinator)

Fully describe the accident (What occurred, what was the injury type, what object directly harmed the employee?):			
What was the employee doing immediately before the accident?:			
What conclusions can be drawn?:			
Comments and/or recommendations to improve safety:			
S & H Coordinator full name:		Work phone #:	
Job title:	Regular shift:	Days off:	
S & H Coordinator's signature:		Date:	

Instructions for Completing the Part-time Employment Calculation Report

This report must be submitted with all applications for benefits for employees who were employed part-time for six weeks prior to the injury.

- Complete the employee's full name
- Complete the date of injury
- Complete the Bureau of Workers' Compensation claim # if available

For the 6 weeks prior to the date of injury, capture the employee's work schedule for every day of the week, including work hours, regularly scheduled days off and any time taken.

Dates should appear in the small box and time worked or taken should appear in the larger box (see example below).

5/12		5/13		5/14		5/15		5/16	
R		8.0		4.0 PL 4.0 V		R		10.0	

ONLY use the codes listed below to document time used

- | | | |
|----------------------------|---------------------------------|-----------------------------|
| A – Absent, no pay | H – Holiday | R – Regular Day Off |
| ADM – Administrative Leave | LDW – Last Day Worked | RTW – Date Returned to Work |
| CT – Comp Time | LOA – Leave of Absence | S – Sick Leave |
| DL – Donated Leave | OIL – Occupational Injury Leave | SC – Salary Continuation |
| DOI – Date of Injury | PL – Personal Leave | V – Vacation |

- For each week, add all hours actually worked and put the total weekly hours in the last column
- Add total weekly hours together to determine total hours for the weeks listed
- Input the numbers into the formula below the calendar to determine daily hours of the part-time employee
- The maximum number of hours per week a part-time employee can receive is **39.9 hours**. Exception may occur the week of the injury.



State of Ohio Part-time Employment Calculation Report

This report must be submitted with all applications for workers' compensation benefits for employees who were employed part-time for six weeks prior to the date of injury. Only complete weeks may be considered. Please fax the completed form to the Third Party Administrator at 614-764-1749.

Employee's Name: _____							Date of Injury: _____
							BWC Claim #: _____
Complete the calendar for six (6) weeks prior to the date of injury.							TOTAL WEEKLY HOURS
SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	
Total Hours (for weeks listed)							

Total Hours _____ divided by _____ # Weeks = _____ Average Weekly Hours

Average Weekly Hours _____ divided by 7 days = _____ Daily Hours (round to nearest ½ hr)

Daily Hours _____ is the part-time benefit hours used for this claim

Signature of Preparer: _____	Phone #: _____	Date: _____
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NOTICE: Failure to accurately complete a *Part-time Employment Calculation Report* for part-time employees filing for workers' compensation benefits, especially Occupational Injury Leave or Salary Continuation, may result in a delay of benefits.

Employee Instructions and Information for completing the OIL Appeal Form *(For Salary Continuation follow Grievance Procedures)*

If a request for Occupational Injury Leave benefits is denied, the employee may appeal the denial by completing the OIL Appeal Form, as the employee **does not** have rights under the grievance procedure.

OIL benefits will end with the denial of the claim and the employee will not be eligible for OIL benefits during the appeal process.

The employee must have this appeal form postmarked within **20 calendar days** from the date of the denial and submitted to the Office of Collective Bargaining, attaching additional information to support the appeal.

Part I – Employee Information

Complete all sections in their entirety

- Your name, OAKS employee ID and home/ mailing address
- The agency and institution/location where you work
- BWC claim number – The claim # assigned by the Ohio Bureau of Workers' Compensation
- Reason for appeal – Be as detailed as possible giving your reason to appeal the decision
- **Additional information must be attached or the appeal will not be addressed**
- Appeal form and supporting documents must be postmarked within 20 days of postmarked denial for appeal to be addressed.
- Due to the sensitive nature of the information provided as supportive documentation, this form and its attachments cannot be faxed or emailed.

DAS Benefits will conduct an initial review of the appeal. If the OIL was denied on procedural issues or the employee failed to provide any new information to support the appeal, DAS Benefits shall issue a letter to the employee denying the appeal and send a copy of the letter, the OIL application and supporting documents to the Union Central Office. DAS Benefits may also grant the claim upon further review.

If the Union determines that further review is necessary, they will submit the request to OCB for a panel to be convened to review the claim within 10 days of receiving documents from DAS Benefits.

The panel will consist of 3 members, a representative of an agency which is not the employing agency and who regularly works with OIL, a Union representative not employed by the employing agency, and a representative or designee of SERB. OCB and Union representatives may attend but will not be voting members of the panel. The panel will complete a file review of the claim and any information provided by the employee and make a determination to uphold or overturn the denial. The panel will issue the decision immediately or within 3 days if further investigation is necessary. The panel's decision will be in writing and will be final. The employee or the employer will be involved in the panel.

If the employee accepts Workers' Compensation temporary total compensation (TT) during the appeal process, he/she may continue to submit extension paperwork. If the employee's appeal is upheld, OIL benefits will be awarded and the agency will work with the employee to repay any Workers' Compensation TT benefits that were awarded.

For Salary Continuation follow Grievance Procedures



OIL Appeal Form

For Salary Continuation follow Grievance Procedures

Part I – Employee Information (completed by employee) An employee has 20 calendar days from the date the initial denial letter is postmarked to file an appeal	
Employee Name:	Employee ID:
Home Address:	
Agency / Location:	BWC Claim #:
Date Denial Received:	Additional information attached? ___Yes___ No
Reason for Filing Appeal:	
<i>Additional information must be attached or the appeal will not be addressed.</i>	
Attention: I acknowledge that employees, whether bargaining unit or exempt, are responsible for adhering to the contract or policy that governs them and that lack of knowledge of the requirements to receive benefits is not sufficient reason to reverse the denial of a benefit. I also acknowledge that this form is for OIL benefits only and can not be used for Salary Continuation. For Salary Continuation employees must follow grievance procedures.	
Employee Signature:	Date:
*** Appeal form and supporting documents must be sent to the Office of Collective Bargaining *** 100 East Broad Street. 14th floor Columbus, OH 43215	
Part II – Union Information (completed by the employee's Union) DAS must render a decision within 10 days and send to the Union's Central Office. The Union must appeal to OCB within 10 days of receiving documents from DAS Benefits	
Appeal to OCB for panel review: (circle) Yes No	Date Received:
Comments / Rationale:	
Signature:	Date:

Employee & Employer Instructions for completing the ADM 4722 Salary Continuation or Occupational Injury Leave Reactivation Request Form

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

Reactivation of SC or OIL benefits, not a BWC reactivation form.

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

Write legibly with a pen or electronically (do not use pencil).

This form is to be used only when applying for an intermittent period or a reactivation of Salary Continuation or Occupational Injury Leave benefits. If you are applying for the first time (initial application), please use form ADM 4303.

Employee Section – Please fully complete all of the requested information.

The injured employee is responsible for completing the entire employee section

- List your name, BWC claim #, date of injury and employee ID# for reference to your initial application.
- You must notify your agency of your absence and expected return to work date.
- Answer all questions to document the progress of your condition.
- Check which benefit type you are requesting (SC or OIL).
- Answer all questions regarding the reason you are requesting reactivation.
- Answer questions related to additional allowances if applicable.
- List the specific dates of disability you are requesting in this application.
- Must seek medical treatment from a **WILMAPC** provider list; call your MCO or visit website

<http://www.das.ohio.gov/Divisions/CollectiveBargaining/Wilmapc/tabid/479/Default.aspx>

Employee Certification / Authorization

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

Employer Section – 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 Paid. Fax all documents to the Third Party Administrator at (614) 764-1749.

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

ADM 4722 SC or OIL Reactivation Request Form

ADM 4741 Calendar of Wages Paid

BWC Medco14 Physician's Report of Work Ability with TREATING DIAGNOSIS identified

SC or OIL Reactivation Request Form

Employee and Employer Statement

Please read the instructions on page 2 before completing the application

PERSONNEL OFFICE USE ONLY
Date Employee Section Received in Office

Employee Section

Employee's name:	BWC Claim #:
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Date of Injury:	Employee ID #:
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Since your last request for benefits, has your condition: <input type="checkbox"/> Improved <input type="checkbox"/> Stayed the same <input type="checkbox"/> Worsened	What is the date of your next doctor's visit? _____ Must receive medical treatment from a WILMAPC provider
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I am requesting a reactivation of my (check which applies) <input type="checkbox"/> SC benefits or <input type="checkbox"/> OIL benefits Date last worked: _____ Date new period of disability began: _____	Reason for reactivation: <input type="checkbox"/> Not progressing in transitional work program (TWP) <input type="checkbox"/> TWP exhausted (reached the maximum time) <input type="checkbox"/> Surgery scheduled – date of surgery: _____ <input type="checkbox"/> Other: please explain: _____
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Have you worked in any other job since the onset of your disability? Yes No
 If yes, 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list the condition(s): _____	I request benefits for (list dates mm/dd/yyyy) : From: _____ / _____ / _____ To: _____ / _____ / _____ Hours requested: _____
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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
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Employer Section

Employer name:	BWC Policy #:
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Total hours requested:	Breakdown of hours requested (please attach a <i>Calendar of Wages</i>): Sick Leave: _____ Vacation: _____ Personal Leave: _____ Comp Time: _____ LOA: _____
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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: _____
 What is the status of a transitional work assignment? _____

Employer Remarks:

Employer Designee Signature	Date
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Instructions for Completing the Calendar of Wages

This report must be submitted with all employee applications for benefits.

- Complete the employee's full name, the Bureau of Workers' Compensation claim # if available, employer name, date of injury
- Complete the form starting with the date of injury and be sure to note the date the employee last worked and the return to work date. If the employee has not returned, please do not use N/A, indicate not yet or an estimated return to work date (ERTW)
- Check the type of benefit the employee is requesting – OIL, SC, TT or disability
- Please indicate if the employee has a fixed schedule or a floating schedule (schedule varies from week to week or changes every other month, etc.)
- Please indicate how many hours a day the employee works and the shift
- If the employee has a fixed schedule, it is imperative to complete the calendar for the week of the injury and the subsequent week
- If the employee has a floating schedule, it is imperative to complete the calendar for the days through the estimated return to work date

ONLY use the codes listed on this form (ADM4741). This will prevent delays and errors in decisions. Because you are completing this form for future benefits, if the employee requested SC, use the SC code for time off.

A – Absent, no pay
 ADM – Administrative Leave
 CSD – Cost Savings Day
 CT – Comp Time
 DL – Donated Leave
 DOI – Date of Injury

ERTW – Estimated Return to Work
 H – Holiday
 LDW – Last Day Worked
 LOA – Leave of Absence
 OIL – Occupational Injury Leave
 PL – Personal Leave

R – Regular Day Off
 RTW – Date Returned to Work
 S – Sick Leave
 SC – Salary Continuation
 TWP – Transitional work
 V – Vacation
 W – Worked

SAMPLES

5/12	5/13	5/14	5/15	5/16	5/17	5/18
W 8	W 8	R	R	W 8	DOI LDW W-6 SC-2	SC 8
5/19	5/20	5/21	5/22	5/23	5/24	5/25
SC 8	R	R	SC 8	SC 8	ERTW	

5/12	5/13	5/14	5/15	5/16	5/17	5/18
R	R	W 8	DOI LDW W-3 SC-5	SC 8	SC 8	RTW



Calendar of Wages

To be completed for all employees filing for workers' compensation benefits.

Employee Name: _____ BWC Claim #: _____

Employer: _____ Date of Injury: _____

Date employee last worked: _____ Date employee returned to work: _____

Employee has filed for: _____ OIL _____ Salary Continuation (SC)

_____ WC - TTD _____ DAS - Disability Benefits

Employee's work schedule: _____ FIXED schedule _____ FLOATING schedule

Employee normally works # hours per day: _____ 8 _____ 10 _____ 12 _____ other, if other note #: _____

Employee works: _____ 1st shift _____ 2nd shift _____ 3rd shift _____ Other-please explain _____

On the calendar below, starting with the date of injury, please indicate the type of leave used on each day.

ONLY use the codes listed below

- | | | |
|----------------------------|---------------------------------|-----------------------------|
| A – Absent, no pay | ERTW – Estimated Return to Work | R – Regular Day Off |
| ADM – Administrative Leave | H – Holiday | RTW – Date Returned to Work |
| CSD – Cost Savings Day | LDW – Last Day Worked | S – Sick Leave |
| CT – Comp Time | LOA – Leave of Absence | SC – Salary Continuation |
| DL – Donated Leave | OIL – Occupational Injury Leave | TWP – Transitional work |
| DOI – Date of Injury | PL – Personal Leave | V – Vacation |
| | | W - Worked |

For the period of: _____

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

Printed Name of Preparer:	Phone #:
Signature of Preparer:	Date:

NOTICE: Failure to complete a *Calendar of Wages* for all workers' compensation claims, especially requests for Occupational Injury Leave and Salary Continuation, may result in the delay of benefits to the injured workers.

Once completed, fax directly to Third Party Administrator at **614-764-1749**.