INSTRUCTIONS FOR COMPLETION OF *ADM4311*
SUPPLEMENTAL REPORT FOR DISABILITY LEAVE BENEFITS

This form is to be used as a supplemental report. If you are filing for initial disability benefits, use form *ADM4310.*

COMPLETION OF FORM

- Type or print legibly.
- All sections of the application must be completed.
- You are responsible for completing the Employee Statement, page 2.
- Your physician is responsible for completing the Attending Physician Statement, pages 3 and 4.
- You are responsible for returning all three (3) pages of the form to your agency by the date given in the last letter sent by Benefits Administration Services.
- You are responsible for any fee the physician may charge for completing the form.

PERSONAL DATA

- You must notify your supervisor of your absence and the expected date of your return to work.

RETURN TO WORK

- To return to work on a part-time basis, you must have the approval of your agency. Only employees receiving full-time disability benefits are eligible to return to work on a part-time basis.
- You must return to work in a Transitional Work Program if recommended by your attending physician and your agency can provide such a program.

WORK RELATED CLAIMS

- You are required to file a claim for lost time wages directly with the Bureau of Workers' Compensation (BWC).

- Disability benefits are not payable for any work-related injury except:

  (1) If your initial application for lost time wages is denied by BWC and you do not appeal the BWC order. You must submit a copy of the BWC denial with the disability application.

  (2) If your initial application for lost time wages is denied by BWC and you appeal the BWC order, you may receive an advancement of disability benefits. You must submit the following with the disability application:

  - a copy of the BWC denial order
  - a completed Disability Agreement, *FORM4313*
  - a copy of your Accident or Illness Report***,*** *FORM4303*
  - a copy of your Request For Temporary Total Compensation, *Form C- 84*

CONFIDENTIALITY

- Claims must be submitted to your agency.
- Claim information submitted directly to Benefits Administration Services will be forwarded to your personnel office.
- Your personnel office is required to keep all information about the nature of your illness/injury confidential.

DISABILITY RETIREMENT

- If your condition is permanent or will last greater than 12 months you may be required to file for disability retirement benefits to continue receiving disability leave benefits.

PHYSICIAN INSTRUCTIONS

- Type or print legibly.
- Complete pages 3 and 4 without expense to the state of Ohio.
- Complete the application as thoroughly as possible
- Retain a copy of both pages of the form.
- The employee is responsible for returning the entire form to their personnel office within a specified time frame. **Failure to timely submit the application may result in the denial of your patient's benefits.**

Disability benefits for state employees are authorized in Administrative Rules 123:1-33-12 through 123:1-33-16, 123:1-33-07 and the bargaining unit contracts.

Information about the Disability Leave Program is available in your *State of Ohio Employee Benefits Handbook* or on the benefits Web site: *http:/www.state.oh.us/das/dhr/benindex.html*

Supplemental Report
Disability Leave Benefits
Employee Statement

Please read the instructions on page 1 before completing this application

PERSONNEL OFFICE USE ONLY
Date Employee's Statement Received in Office (Date Stamp Preferred)

Employee's Name	Social Security Number
Address Street	City State Zip
Telephone (area code) Home Work	E-mail address
Have there been any changes in your condition since your original claim? Yes No If yes, please explain.	
Are there any conditions that have become disabling that were caused by or resulting from your job? Yes ______ No______ If yes, please describe	
Have you been hospitalized since your original claim? Yes ____ No ____	If yes, give dates of confinement
Name of Hospital	Reason for confinement
Have you returned to work? If yes, give date: Yes ____ No _____	If no, what date to you expect to return?
Are you returning to work part-time and applying for disability benefits on a part-time basis? Yes ____ No ____	
Have you engaged in any occupation for wage or profit since the onset of your disability? Yes No	If yes, did you receive compensation? Yes ____ No ____
Place of Employment: Telephone : Provide dates worked:	Address:
If your claim was not as an advancement of workers' compensation, have any conditions become disabling that were caused by or resulting from your job? Yes ____ No ____ If yes, please describe:	

EMPLOYEE CERTIFICATION/AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize any hospital or clinic, physician, nurse or practitioner, including my health plan, the state's mental health vendor, United Behavioral Health (UBH), the Employee Assistance Program (EAP), the Bureau of Workers' Compensation, the retirement system which I participate in or any other person, office or provider with knowledge of my illness, injury or condition to provide the Department of Administrative Services or its representatives and state agencies involved with my return to work or claim for disability benefits with complete information as to my health and medical history, eligibility for Disability Retirement Benefits and any information required in connection with this claim, hereby waiving any and all privileged character of such information. I also hereby authorize the Department of Administrative Services or its representative to release any such information it receives to my health plan, the state's mental health vendor, United Behavioral Health (UBH), the Employee Assistance Program (EAP), the Bureau of Workers' Compensation, the retirement system which I participate in and state agencies involved with my return to work or claim for disability benefits. I understand my health plan, the state's mental health vendor, United Behavioral Health (UBH), state agencies or other party acting as a representative for the state may contact me regarding their services in assisting me to return to work. A photocopy of this authorization shall bevalid as the original. I understand that it is my responsibility under ADA to contact my employer if I wish to apply forreasonable accommodations under ADA or to obtain information about my rights under ADA.

I have read and understand the instructions on page 1 of this application. I certify that the above statements are true to the best of my knowledge and understand any misrepresentation on my part may result in a denial of my benefits.

This authorization will be valid for 180 days from date of signature.

Date	Employee's Name

Please Note: Employee is responsible for returning pages 2, 3 and 4 of this form to employing agency. Claim information submitted directly to Benefits Administration Services will be forwarded to the employee's personnel office. The personnel office is required to keep all information about the nature of the illness/injury confidential.

Supplemental Report

Attending Physician Statement

Instructions for completing this form are on page 1 of the application.

Please attach copies of office notes, evaluations and testing results
Insufficient evidence may result in disapproval.

Employee Name	Date of Birth	Social Security Number

Diagnosis of disabling condition (s)

Diagnosis ____ ICD-9 _______________

Diagnosis ____ ICD-9 _______________

Diagnosis ____ ICD-9 _______________

Treatment dates since last report	Date of next appointment
Has patient been hospitalized since initial claim	Dates of hospitalization
Reason for hospitalization and/or type of surgery performed	Name of Hospital

If surgery performed, give date

Mo. _____ Day _____ Yr. _____

Complications or other factors delaying recovery (describe)

Subjective symptoms. (If psychiatric, describe mood and affect, ability to relate, ability to carry out daily activities, follow instructions, judgment, and ability to concentrate)

List any **change** in medication since onset of disability

Medications	Dosage	Date initiated

Plan of treatment for a return to work.

Employee Name

What restrictions are placed on patient's work activities?

What job duties is the patient unable to perform?

1. In an 8-hour workday, person can: (mark full capacity for each activity)

TOTAL (hours)	Sit	Stand	Walk
	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	5 6 7 8	5 6 7 8	5 6 7 8

2. Person can lift and carry

	Never	Occasionally (1%-33%)	Frequently (34%-66%)	Constantly (67%-100%)
Up to 10 lbs.	________	________	________	________
11-20 lbs.	________	________	________	________
21-50 lbs.	________	________	________	________
51-100 lbs.	________	________	________	________
Over 100 lbs.	________	________	________	________

3. Person can push/pull:

	Never	Occasionally (1%-33%)	Frequently (34%-66%)	Constantly (67%-100%)
Up to 10 lbs.	________	________	________	________
11-20 lbs.	________	________	________	________
21-50 lbs.	________	________	________	________
51-100 lbs.	________	________	________	________
Over 100 lbs.	________	________	________	________

4. Person can do repetitive movements as in operating controls:

Right hand/arm _____ Yes _____ No   Left hand/arm _____ Yes _____ No

5. Other restrictions:

Patient's condition prevents them from working:

Temporarily _____ **For longer than 12 months** _____ **Permanently** _____

If disability is temporary, patient's estimated date of release to return to work:

___ For regular occupation   Mo. _____ Day _____ Yr. _____

___ On a part-time basis   Mo. _____ Day _____ Yr. _____

part-time schedule:

hours per day _________ days per week _________ # of weeks _________

___ For suitable work activities within the limitations listed above   Mo. _____ Day _____ Yr. _____

Additional Remarks

Name (treatment provider) Please print		Specialty		Fed ID#
Street Address	City	State		Zip Code
Telephone (area code)		Fax (area code)	E-mail address	
Date form received	Date signed	Signature		