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 State of Ohio User 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 #:
Date of Injury:	State of Ohio User ID #:

Since your last request for benefits, has your condition:

_____ Improved _____ Stayed the same _____ Worsened

What is the date of your next doctor's visit? _____

Must receive medical treatment from a WILMAPC provider

I am requesting a reactivation of my (check which applies)

_____ SC benefits or _____ OIL benefits

Date last worked: _____

Date new period of disability began: _____

Reason for reactivation:

_____ Not progressing in transitional work program (TWP)

_____ TWP exhausted (reached the maximum time)

_____ Surgery scheduled – date of surgery: _____

_____ Other: please explain:

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?
_____ Yes _____ No

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

I request benefits for (list dates mm/dd/yyyy) :

From: _____ / _____ / _____

To: _____ / _____ / _____

Hours requested: _____

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

Employer Section

Employer name:	BWC Policy #:
Total hours requested:	Breakdown of hours requested (please attach a *Calendar of Wages):* Sick Leave: _____ Vacation: _____ Personal Leave: _____ Comp Time: _____ LOA: _____

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