Ohio | Industrial Commission

Claim Number:

(Use the claim #with the most recent date of injury or diagnosis)

APPLICATION FOR COMPENSATION FOR PERMANENT TOTAL DISABILITY

1. Each application for permanent total disability shall identify, if already on file, or be accompanied by medical evidence supporting the application. If documents are already on file, there is no need to resubmit them.
   a. The medical examination upon which the report is based must have been **performed within twenty-four months prior to the date of filing of the application for permanent total disability compensation (document information below).**
   b. If an application for permanent total disability compensation is filed that does not meet the filing requirements of Ohio Adm.Code **4121-3-34**, or if proper medical evidence is not filed or identified within the claim file, the application **shall be dismissed** without hearing.

2. The completed application should be filed at an Industrial Commission office.

3. **If permanent total disability is granted, the injured worker is not permitted to return to work in any capacity.**

Injured Worker's Information	
Name	Date of Birth
Address	
City, State, Zip	
Telephone	Fax

Injured Worker's Representative Information	
Rep ID#	
Name	
Telephone	Fax

☐ Consider All Claims

☐ Consider only the injured worker's claim numbers listed below when processing this application (claims with similar body parts will be considered):

Claims not listed here will not be considered and cannot be added at the time of your hearing.

By not listing a claim, you cannot then argue that the allowed conditions in that claim prevent you from working. This does not preclude future benefits and/or medical treatment for the named conditions in the claim.

If you have not checked the "Consider All Claims" box, the Industrial Commission will include all claims containing similar body parts to those conditions in the claims that have been identified.

☐ I have attached the required medical documentation to support this application for permanent total disability.

Date of Exam _____ (mm/dd/yyyy) Physician Name _____

Date of Exam _____ (mm/dd/yyyy) Physician Name _____

☐ Medical documentation listed below has been previously filed and supports this application for permanent total disability.

Claim _____ Date of Exam _____ (mm/dd/yyyy) Physician Name _____

Claim _____ Date of Exam _____ (mm/dd/yyyy) Physician Name _____

Claim _____ Date of Exam _____ (mm/dd/yyyy) Physician Name _____

Medical documentation listed above must opine only on the allowed conditions in the claims you have identified above or the application for permanent total disability will be dismissed. If necessary, please attach additional information.

Claim Number:

MEDICAL HISTORY

List all of the physicians you have seen in the last five years, their addresses, and for what condition(s) you have seen them:

Physician's Name	Physician's Address	Condition(s)

List all of the surgeries and procedures you have had, beginning with the most recent:

Surgery/Procedure	Physician's Name	Date (mm/dd/yyyy)

Do you use any medical equipment such as a cane, brace, walker, wheelchair, oxygen or TENS unit? ☐ Yes ☐ No

If yes, please specify: _____

_____

Do you have any other medical conditions that impact your ability to work? _____

_____

_____

DAILY ACTIVITIES

Has your treating doctor told you to restrict or limit your activities due to your injuries? ☐ Yes ☐ No

If yes, please specify: _____

_____

Do you drive a vehicle? ☐ Yes ☐ No How far can you drive at one time? _____

How far can you walk at one time? _____ How long can you stand at one time? _____

How long can you sit at one time? _____ How long do you sleep each night? _____

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DAILY ACTIVITIES CONTINUED

Are you involved in any organizations, clubs, charities or associations of any kind, either as a volunteer or member? ☐ Yes ☐ No

If yes, please provide name of organization and nature of association: _____

_____

Do you have hobbies or engage in recreational or social activities? ☐ Yes ☐ No

If yes, please specify: _____

_____

Do you dress yourself? ☐ Yes ☐ No ☐ Need Assistance

Do you shower or bathe yourself? ☐ Yes ☐ No ☐ Need Assistance

Do you prepare any meals? ☐ Yes ☐ No

Do you do any housework/yardwork (laundry, repairs, grocery shopping, grass cutting etc.)? ☐ Yes ☐ No

If yes, please specify: _____

_____

_____

_____

_____

What is the most weight you lift on a daily basis? _____

Describe any other limitations or changes in your lifestyle, if any, resulting from the allowed condition(s) in your claim(s): _____

_____

_____

_____

_____

OTHER DISABILITY BENEFITS

Have you ever filed for Social Security Disability benefits? ☐ Yes ☐ No

If you are now, or have ever, received Social Security Disability payments, complete the following section. This **does not** apply to Social Security Retirement.

Starting Date _____ (mm/dd/yyyy) Termination Date _____ (mm/dd/yyyy)

What was the reason for termination? _____

Do you receive disability benefits other than Social Security? (i.e.: VA, Fireman & Police Officer Disability, etc.)? ☐ Yes ☐ No

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VOCATIONAL REHABILITATION HISTORY

Have you sought or been offered vocational rehabilitation services? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

_____

EDUCATION

What is the highest grade of school you completed? _____ When? _____ (mm/dd/yyyy)

Where? _____ (School, City)

Did you graduate from high school? ☐ Yes ☐ No

If yes, which curriculum? ☐ Special Education ☐ Standard ☐ College Preparatory

If no, did you receive a certificate for passing the General Educational Development test (GED)? ☐ Yes ☐ No

Why did you end your schooling? _____

Have you gone to trade or vocational school or had any type of training? ☐ Yes ☐ No

If yes, what type of trade school, vocational schooling or special training have you received and when?

_____

How has this schooling or training been used in any of the work you have done? _____

_____

Can you read? ☐ Yes ☐ No If yes, what language(s)? _____

Can you write? ☐ Yes ☐ No If yes, what language(s)? _____

What languages can you speak? _____

Can you do basic math? ☐ Yes ☐ Not Well ☐ No

Do you have basic computer skills (keyboarding; business office software applications such as Microsoft Office; using and creating spreadsheets)? List all software with which you are proficient. _____

_____

_____

_____

WORK HISTORY

What is the last date you worked in any capacity, including contractor work or self-employment: _____ (mm/dd/yyyy)

Do you have military experience? ☐ Yes ☐ No

If yes, provide your last date of service: _____ (mm/dd/yyyy)

Include your military service information in the work history list starting on the next page.

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When completing the following sections of the application, please be specific and as detailed as possible. **A thorough work history is very important when processing an application for permanent total disability.** Attach additional pages as needed providing the same information as listed below for past positions held. Include all military service and past positions.

Title of Most Recent Job

Name of Employer

Dates Worked From: (mm/dd/yyyy) To: (mm/dd/yyyy) Hours per Week

Describe your basic duties:

List machines, tools, and equipment, including computer equipment, you used:

Describe technical knowledge and skills you used:

Describe reading and writing you did:

Did you supervise people? ☐ Yes ☐ No If yes, how many?

Describe the kind and amount of physical activity this job involved during a typical day:

Walking (circle the number of hours a day spent walking) 0 1 2 3 4 5 6 7 8

Standing (circle the number of hours a day spent standing) 0 1 2 3 4 5 6 7 8

Sitting (circle the number of hours a day spent sitting) 0 1 2 3 4 5 6 7 8

Bending (circle how often a day you had to bend) Never Occasionally Frequently Constantly

Check the heaviest weight lifted occasionally: ☐ Up to 10 lbs. ☐ Up to 20 lbs. ☐ Up to 50 lbs. ☐ Up to 100 lbs. ☐ Over 100 lbs.

Check the weight frequently lifted/carried: ☐ Up to 10 lbs. ☐ Up to 20 lbs. ☐ Up to 50 lbs. ☐ Up to 100 lbs. ☐ Over 100 lbs.

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SPECIAL FACTORS

Please use this space for comments, explanations or special factors (social, economic, psychological) you wish to add to support your application.

ATTENTION

This application will be dismissed if not signed by the injured worker or if the medical evidence supporting the request for Permanent Total Disability is not attached or identified as previously filed.

I, _____ , certify that the information on this page
Injured Worker's Name
and the preceding pages is true to the best of my knowledge. By signing this application, I expressly waive all provisions of law which forbid any person, persons or medical facility who has medically attended, treated, or examined me, or who may have medical information of any kind which may be used to render a decision in my claim, from disclosing such knowledge or information to the Industrial Commission or employer(s) in my claim(s).

Help Us, Help You!

Please take a minute to give us your correct address in the space provided on the first page of this application.

Injured Worker's Name: Date:	Person Completing this Form: Date:
Signature	Signature