Ohio | Industrial Commission

Claim Number:

AGREEMENT AS TO COMPENSATION FOR PERMANENT PARTIAL DISABILITY

Injured Worker's Information		Employer's Information	
Name		Name	
Address		Address	
City, State, Zip		City, State, Zip	
Telephone	Fax	Telephone	Fax
Injured Worker's Representative's Information		**Employer's Representative's Information**	
Rep ID#		Rep ID#	
Name		Name	
Telephone	Fax	Telephone	Fax

AGREEMENT

This agreement is entered into by and between all interested parties under the authority granted by the Industrial Commission of Ohio and is subject to such change and modifications as may be ordered by the Industrial Commission of Ohio.

Therefore, we, the below signed parties, hereby agree that the Injured Worker sustained an injury on _____ (mm/dd/yyyy)

and that the said claim has been recognized for _____

_____

☐ It is further agreed that the Injured Worker has a percentage of permanent partial disability of _____ %, which would entitle him/her to an award for the period of _____ weeks; that if the date of injury in this claim is prior to 08/22/1986, the Injured Worker must elect whether to receive compensation as above determined or to be compensated for impairment of earning capacity; and, that the Injured Worker's average weekly wage is $ _____ which would entitle him/her to a rate of $ _____ per week.

☐ It is further agreed that the Injured Worker's percentage of permanent partial disability has increased and is now _____ %, which is an increase of _____ %; therefore, that he/she is entitled to an additional award of compensation for the period of _____ weeks; and, that the injured worker's average weekly wage is $ _____ which would entitle him/her to a rate of $ _____ per week.

☐ It is further agreed that the Injured Worker has sustained the loss by amputation or ankylosis or the permanent total loss of use of _____ ; therefore, that such loss would entitle him/her to an award for the period of _____ weeks; and, that the statewide average weekly wage is $ _____ which would entitle him/her to a rate of $ _____ per week.

WAIVER OF NOTICE OF HEARING AND WAIVER OF RIGHT OF APPEAL

So that the Injured Worker herein may promptly receive payment of his/her award, the parties hereto waive notice of hearing on the application filed _____ (mm/dd/yyyy) **AND** further waive their right to appeal an order entered pursuant to this agreement.

☐ By checking this box, I certify that I am a non-attorney representative who has been authorized and directed to file this agreement by the ☐ Injured Worker ☐ Employer.

READ THIS DOCUMENT CAREFULLY BEFORE SIGNING.

BY EXECUTING THIS DOCUMENT YOU HAVE WAIVED YOUR RIGHT TO A HEARING, WAIVED YOUR RIGHT TO FILE AN OBJECTION/APPEAL, AND HAVE AGREED TO THE PAYMENT OF PERMANENT PARTIAL DISABILITY COMPENSATION.

Injured Worker or Representative	Employer or Representative	BWC Administrator