



The Industrial Commission of Ohio

APPLICATION FOR COMPENSATION FOR PERMANENT TOTAL DISABILITY

*Please type or print clearly and answer all questions to the best of your ability.
Your cooperation in completing this form will aid in processing this application on a timely basis.
*To assure prompt processing, this application should be filed directly with:

The Industrial Commission of Ohio
Medical Services
30 W. Spring St. 1st floor
Columbus, Ohio 43215-2233

Form with fields for Claimant's Name, Social Security Number, Date of Birth, Address, Telephone Number, City, State, and Zip Code.

List all of your Workers' Compensation claims that you want to have considered in the processing of this application

All Claims (If you check this box, list only your most recent claim number below)

Four rows of fields for Claim Number, Date of Injury, and Employer.

Medical examinations will only be conducted for conditions allowed in the above listed claims.

I am permanently and totally disabled as the result of the injuries sustained in the forgoing claim(s) and request that the Industrial Commission grant compensation for such disability. I further state that Dr. _____ has certified that I will never be able to return to my former position of employment and attached to this form is a copy of the doctor's report. When was the last date you worked anywhere? _____.

OTHER DISABILITY BENEFITS

Have you ever filed for Social Security Disability benefits? yes no

If you are now, or ever have, received Social Security Disability payments, complete the following section.

This does not apply to Social Security Retirement

Table with columns: STARTING DATE, TERMINATION DATE AND REASON FOR TERMINATION, RATE PER MONTH

Do you receive disability benefits other than Social Security? (i.e., VA, Fireman & Police Officer Disability, etc.) yes no

EDUCATION

What is the highest grade of school you completed? When? Where?

Did you graduate from high school? yes no
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 special training? yes no

Notice: IC USE ONLY
Upon receipt of this application, forward immediately to The Industrial Commission of Ohio, Medical Services at the address indicated above.

If yes, what type of trade school 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 not well no

Can you write? yes not well no

Can you do basic math? yes not well no

MEDICAL HISTORY

Doctor's Name _____ Address _____

Date first seen _____ Date last seen _____

Reason _____

Doctor's Name _____ Address _____

Date first seen _____ Date last seen _____

Reason _____

Doctor's Name _____ Address _____

Date first seen _____ Date last seen _____

Reason _____

List all operations and surgical procedures you have undergone, beginning with the most recent.

Date _____ Name of surgical procedure _____

Do you use a cane, brace, TENS unit, traction device, oxygen machine, or any other appliance or device on a regular basis? yes no

If yes, please specify. _____

What other medical conditions prevent you from working? _____

REHABILITATION HISTORY

Have you ever participated in rehabilitation services? yes no Please explain _____

If you have not sought or participated in rehabilitation services, are you interested in rehabilitation services offered by the employer or the Bureau of Workers' Compensation and do you desire to undergo rehabilitation evaluation? yes no

Describe other limitations or changes in your lifestyle. _____

DAILY ACTIVITIES

Has your treating physician told you to cut back or limit your activities in any way? ___Yes ___ No
 If yes, give the name of the doctor and tell below what he told you about cutting back or limiting your activities.

Can you drive a car? ___ Yes ___ No

Describe your daily activities in the following areas and how much you do of each and how often.

Housekeeping Chores: (meal preparation, laundry, home repairs, etc.) _____

Recreational Activities and Hobbies: (bowling, hunting, etc.) _____

Describe other limitations or changes in your life style, if any, resulting from the allowed conditions in your claim.

WORK HISTORY

Part 1 INFORMATION ABOUT YOUR WORK HISTORY

List all the jobs you have had. Start with your most recent job first and then work backwards to the first job you ever held.

List SELF-EMPLOYMENT as you would any other job.

	Job Title (Be sure to begin with your most recent job)	Type of Business or Industry (Example: auto, insurance, construction, etc.)	Dates Worked (Month and Year)		Days Per Week	Specify Rate of Pay (per hour, day, week, month or year)
			From	To		
1						
2						
3						
4						
5						
6						
7						
8						

Do you have military experience?

yes no

If yes, provide dates of service,

positions held and description of duties _____



Job Title No. 1 (from Part 1) _____



Describe your basic duties - what you did and how you did it. Please provide as much detail as possible.

1. Your basic duties: _____

2. Machines, tools, equipment you used: _____

3. Exact operations you performed: _____

4. Technical knowledge and skills you used: _____

5. Reading / Writing you did: _____

6. Number of people you supervised: _____

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 below the heaviest weight lifted, weight frequently lifted and / or carried.

Heaviest weight lifted:		Weight frequently lifted / carried:	
<input type="checkbox"/> 10 lbs.	<input type="checkbox"/> 100 lbs.	<input type="checkbox"/> Up to 10 lbs.	<input type="checkbox"/> Up to 50 lbs.
<input type="checkbox"/> 20 lbs.	<input type="checkbox"/> Over 100 lbs.	<input type="checkbox"/> Up to 25 lbs.	<input type="checkbox"/> Over 50 lbs.
<input type="checkbox"/> 50 lbs.			

Job Title No. 2 (from Part 1) _____



Describe your basic duties - what you did and how you did it. Please provide as much detail as possible.

1. Your basic duties: _____

2. Machines, tools, equipment you used: _____

3. Exact operations you performed: _____

4. Technical knowledge and skills you used: _____

5. Reading / Writing you did: _____

6. Number of people you supervised: _____



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

- 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 below the heaviest weight lifted, weight frequently lifted and / or carried.

- | | | | |
|----------------------------------|--|--|--|
| Heaviest weight lifted: | | Weight frequently lifted / carried: | |
| <input type="checkbox"/> 10 lbs. | <input type="checkbox"/> 100 lbs. | <input type="checkbox"/> Up to 10 lbs. | <input type="checkbox"/> Up to 50 lbs. |
| <input type="checkbox"/> 20 lbs. | <input type="checkbox"/> Over 100 lbs. | <input type="checkbox"/> Up to 25 lbs. | <input type="checkbox"/> Over 50 lbs. |
| <input type="checkbox"/> 50 lbs. | | | |

Job Title No. 3 (from Part 1) _____



Describe your basic duties - what you did and how you did it. Please provide as much detail as possible.

1. Your basic duties: _____

2. Machines, tools, equipment you used: _____

3. Exact operations you performed: _____

4. Technical knowledge and skills you used: _____

5. Reading / Writing you did: _____

6. Number of people you supervised: _____



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

- 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 below the heaviest weight lifted, weight frequently lifted and / or carried.

Heaviest weight lifted:

Weight frequently lifted / carried:

10 lbs.

100 lbs.

Up to 10 lbs.

Up to 50 lbs.

20 lbs.

Over 100 lbs.

Up to 25 lbs.

Over 50 lbs.

50 lbs.

Job Title No. 4 (from Part 1) _____



Describe your basic duties - what you did and how you did it. Please provide as much detail as possible.

1. Your basic duties: _____

2. Machines, tools, equipment you used: _____

3. Exact operations you performed: _____

4. Technical knowledge and skills you used: _____

5. Reading / Writing you did: _____

6. Number of people you supervised: _____



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

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 below the heaviest weight lifted, weight frequently lifted and / or carried.

Heaviest weight lifted:

Weight frequently lifted / carried:

10 lbs.

100 lbs.

Up to 10 lbs.

Up to 50 lbs.

20 lbs.

Over 100 lbs.

Up to 25 lbs.

Over 50 lbs.

50 lbs.

SPECIAL FACTORS

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

I certify that the information on this page and the preceding pages are 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).

Attached to this application is medical evidence in support of the application.

_____ **X** _____
Person Completing This Form Claimant's Signature

X _____
Date

DO NOT submit this application without the following:

- * Supporting medical evidence signed by the physician.
- * Your signature on this application. (above)

ATTENTION
This application will be dismissed if medical evidence supporting the request for Permanent Total Disability is not attached.

To assure prompt processing, this application should be filed directly with:

**The Industrial Commission of Ohio
Medical Services
30 W. Spring St. 1st floor
Columbus, Ohio 43215-2233**

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.