Ohio | Industrial Commission

Claim Number:

AGREEMENT AS TO AWARD FOR PERMANENT TOTAL DISABILITY

Instructions:

- Type or print clearly and provide all requested information and signatures.
- If all parties do not agree on all terms, this application will not be processed per Industrial Commission Rule 4121-3-34 (C) (3) (a).
- Medical evidence substantiating PermanentTotal Disability must accompany this form.

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

Injured Worker's last date worked: _____ (mm/dd/yyyy)

Has the injured worker ever filed for Social Security Disability benefits? ☐ Yes ■ No

If "Yes" and Social Security Disability payments were received, provide the information below:

Starting Date _____ (mm/dd/yyyy) Rate Per Month $ _____

Termination Date _____ (mm/dd/yyyy) Termination Reason (if applicable): _____

The parties below agree that the above injured worker is permanently and totally disabled due to the allowed conditions of the claims listed below and that an award of permanent total disability compensation should commence effective _____ (mm/dd/yyyy) and be allocated as follows:

Claim Number	Allocation (%)
	0.00%
	0.00%
	0.00%
Total:	100%

By executing this agreement, the parties waive formal hearing and acknowledge that a commission order will be entered after decision on the written record.

Injured Worker or Attorney's Signature (required)	○ Agree ○ Disagree	Date
Employer or Attorney's Signature (required)	○ Agree ○ Disagree	Date
Employer or Attorney's Signature	○ Agree ○ Disagree	Date
Employer or Attorney's Signature	○ Agree ○ Disagree	Date
Administrator of Bureau of Workers' Compensation (if applicable)	○ Agree ○ Disagree	Date