

\*Please type or print clearly and answer ALL questions to the best of your ability.  
 \*To ensure prompt processing, this application should be filed directly with:

The Industrial Commission of Ohio  
 Medical Services  
 30 W. Spring St. 10th floor  
 Columbus, Ohio 43215-2233

Injured Worker's Name	Social Security Number	Date of Birth
Address		Telephone Number (     )
City	State	Zip Code

**List your worker's compensation claims below:**

Claim Number \_\_\_\_\_ Date of Injury \_\_\_\_\_ Employer \_\_\_\_\_

Claim Number \_\_\_\_\_ Date of Injury \_\_\_\_\_ Employer \_\_\_\_\_

Claim Number \_\_\_\_\_ Date of Injury \_\_\_\_\_ Employer \_\_\_\_\_

Claim Number \_\_\_\_\_ Date of Injury \_\_\_\_\_ Employer \_\_\_\_\_

Medical examinations will be conducted for conditions allowed in active claims.

**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	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 \_\_\_\_\_

Date \_\_\_\_\_ Name of surgical procedure \_\_\_\_\_

Date \_\_\_\_\_ Name of surgical procedure \_\_\_\_\_

Date \_\_\_\_\_ Name of surgical procedure \_\_\_\_\_

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

**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

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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.) \_\_\_\_\_

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

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

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**WORK HISTORY**

**Part 1 INFORMATION ABOUT YOUR WORK HISTORY**

List all the jobs you have had. Start with your most recent job and 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						

When was the last date you worked anywhere? \_\_\_\_\_

Do you have military experience?  yes  no If yes, provide dates of service,  
positions held and description of duties. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Job Title No. 1 (from Part 1)** \_\_\_\_\_

**A**

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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**B**

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 and 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)** \_\_\_\_\_

**A**

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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**B**

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 and 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) \_\_\_\_\_**

**A**

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: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**B**

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 and weight frequently lifted and / or carried.

Heaviest weight lifted:

10 lbs.

20 lbs.

50 lbs.

100 lbs.

Over 100 lbs.

Weight frequently lifted / carried:

Up to 10 lbs.

Up to 25 lbs.

Up to 50 lbs.

Over 50 lbs.

**A**

**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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**B**

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 and weight frequently lifted and / or carried.

Heaviest weight lifted:

10 lbs.

20 lbs.

50 lbs.

100 lbs.

Over 100 lbs.

Weight frequently lifted / carried:

Up to 10 lbs.

Up to 25 lbs.

Up to 50 lbs.

Over 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)

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I certify that the information on this page 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).

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 have physical and/or mental impairments resulting from the allowed conditions in my claims that permanently preclude me from returning to my former position of employment. I have attached to this form a copy of the doctor's report.

\_\_\_\_\_  
Person Completing This Form

**X**  
\_\_\_\_\_  
Injured Worker'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 ensure prompt processing, this application should be filed directly with:

**The Industrial Commission of Ohio  
Medical Services  
30 W. Spring St. 10th 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.