

- * Type or print clearly and provide all requested information and signatures on both sides of this form. 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 Permanent Total Disability must accompany this form.
- * Fax this form to 614-466-7472 or file 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

Injured worker's last date worked: _____
 Has the injured worker ever filed for Social Security Disability benefits? Yes No
 If Social Security Disability payments are or were received, provide this information:

Starting Date	Rate per month	Termination date and 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 _____ and be allocated as follows:
Date

Claim Number	Allocation (%)
_____	_____
_____	_____
_____	_____
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.

Signature	Date	Agree/Disagree
_____ Injured worker or Attorney	_____	_____
_____ Employer or Attorney	_____	_____
_____ Employer or Attorney	_____	_____
_____ Employer or Attorney	_____	_____
_____ Administrator of the Bureau of Workers' Compensation, if any listed claim is state funded or bankrupt self-insured	_____	_____