REPORT OF EMPLOYER FOR DISABILITY BENEFIT APPLICANT

Ohio Public Employees Retirement System
277 East Town Street, Columbus, Ohio 43215-4642

1-800-222-PERS (7377)
www.opers.org

STEP 1: Employee's Personal Information

Social Security Number

-OR-

OPERS ID

First Name

MI

Last Name

Date of Birth

Gender: ◯ Male ◯ Female

Address

City

State

ZIP Code

STEP 2: Certification by Department Head

1. Employee's Job Title (Employee's Job Title must match title on job description)

2. Who initiated the application for disability? ◯ Employee ◯ Employer

3. *This question is only for employees who are law enforcement officers.* Is the disabling condition the result of an on-duty illness or injury that occurred during or resulted from the performance of duties under the direct supervision of the employee's appointing authority? ◯ Yes ◯ No

If "Yes", explain and provide the date the illness or injury occurred:

See next page

STEP 2: Certification by Department Head *(continued)*

4. Employer Reported Physical Job Demands (this section must be completed for all applicants).

Employer Reported Member Job Restrictions and/or Limitations Form *Max = Maximum lifting/carrying/pushing/pulling capacity - (lbs.)					
Address all below if applicable:	Max*	Not Applicable	**Occasional** 0-2.6 hrs/day	**Frequent** 2.7-5.3 hrs/day	**Constant** 5.4-8 hrs/day
Low Lift (floor to knuckle)					
Mid Lift (knuckle to shoulder)					
Full Lift (floor to shoulder)					
Carrying					
Pushing					
Walking	N/A				
Climbing	N/A				
Balance	N/A				
Stoop	N/A				
Kneeling	N/A				
Crouching	N/A				
Crawling	N/A				
Reaching (immediate)	N/A				
Reaching (overhead)	N/A				
Handling	N/A				
Fingering	N/A				
Feeling	N/A				
Sitting	N/A				
Standing	N/A				

General remarks regarding additional physical/mental job demands:

See next page

STEP 2: Certification by Department Head *(continued)*

Did you require the member attain any additional education, skills or certification since they were hired?

◯ Yes ◯ No

If yes, please list:

Department Head First Name MI Last Name

Title

Employer E-mail Address

Primary Office Contact

Primary Office Contact Phone Number Fax Number

— — — —

Primary Office Contact E-mail Address

Office Hours

Preferred Time to Call:

◯ Morning ◯ Afternoon ◯ Evening

Preferred Method of Contact:

◯ Phone ◯ Fax ◯ E-mail

Signature ______________________________ Today's Date ____/____/____

Do not print or type name

See next page

STEP 3: Certification by Fiscal Officer

I certify that the applicant listed on the front of this form was/is an employee of:

Employer

Department/Division

Check ONLY one of the following and provide the date if applicable:

◯ The final date for which this employee was/will be compensated is: ___ / ___ / ___

◯ The final date of compensation is not known. I certify the final date of compensation will be provided pending the OPERS Board of Trustees approval of the Application.

Fiscal Officer Reporting to OPERS First Name | MI | Last Name

Title

Department

Work Phone Number

___ — ___ — ___

Signature ______________________________ Today's Date ___ / ___ / ___

Do not print or type name