Ohio | **Bureau of Workers' Compensation**

Request for Temporary Total Compensation

Injured worker demographics

1

Name		Claim number		Date of injury
Address	City		State	Nine-digit ZIP code
Email address (optional)		Home phone number — —		Cell phone number — —

Disability information

2

- Is this application requesting a new period of temporary total compensation or an extension? ☐ New ☐ Extension
- If this is a new period, what was the last date worked due to the current period of work-related disability? ____/____/____
- List all providers **currently** treating you for this work-related disability claim. _____

Employment information

3

What was your occupation at the time of the injury/disease? _____

- Do you have a job to return to? ☐ Yes ☐ No ☐ I don't know
  - o If yes, who is your employer? _____
  - o If yes, does your employer offer modified (light-duty) work? ☐ Yes ☐ No ☐ I don't know
  - o If yes, do you feel capable of performing any of your job duties at this time? ☐ Yes ☐ No
    If yes, what duties? _____

Working includes full or part-time, self-employment, income-producing hobbies, commission work, or unpaid activities that are not minimal and directly earn income for someone else.

- Are you currently working in any capacity (as defined above)? ☐ Yes ☐ No
  - o If yes, who is your employer? _____
- Have you previously worked in any capacity (as defined above) during this requested period of disability? ☐ Yes ☐ No
  - o If yes, who is your employer? _____
  - o If no, when was the last date you worked anywhere? ____/____/____ Reason for leaving _____
- What do you feel is preventing you from returning to work at this time? Please describe physical, employment and personal barriers.

Vocational rehabilitation information

4

Vocational rehabilitation is an individualized and voluntary program for an eligible injured worker who needs assistance in safely returning to work or in retaining employment. This program can be tailored around an injured worker's restrictions and may provide job-seeking skills or necessary retraining.

- If appropriate, would you consider participating in vocational rehabilitation? ☐ Yes ☐ No If no, why not? _____

Benefits/earnings received or requested during the period of disability

5

Type of benefit	Receiving	Beginning date of benefit
Unemployment **If yes, from which state are you receiving benefits?** _____	☐ Yes ☐ No	
Social Security retirement	☐ Yes ☐ No	
Public assistance **If yes, include case number:** _____	☐ Yes ☐ No	
Sick leave **If yes, name of company paying the benefit:** _____	☐ Yes ☐ No	
Wage/salary continuation **If yes, name of company paying the benefit:** _____	☐ Yes ☐ No	
Disability **If yes, name of company paying the benefit:** _____	☐ Yes ☐ No	
Earnings **(to include full or part time, self employment, income-producing hobbies or commission work)** **If yes, name of employer and job duties.** _____	☐ Yes ☐ No	

Injured worker signature

6

I understand I am not permitted to work while receiving temporary total compensation. I have answered the foregoing questions truthfully and completely. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by BWC or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine, imprisonment or both.

Signature	Date