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
This section is required to be completed or the form will be invalid.

Social Security Number ___ — __ — ____ **-OR-** OPERS ID

First Name

MI

Last Name

Date of Birth __ / __ / ____

Gender: ◯ Male ◯ Female ◯ Prefer Not To Say

Address

City

State

ZIP Code

STEP 2: Certification by Department Head
This section is required to be completed or the form will be invalid.

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)* This section is required to be completed or the form will be invalid.

4. Employer Reported Physical Job Demands (this section must be completed for all applicants). **Please complete as the job is commonly performed NOT based on what the applicant is capable of performing.**

Employer Reported Physical Job Demands						
EXERTIONAL ACTIVITIES						
Address all below:	< 10 lbs	10 lbs	20 lbs	25 lbs	50 lbs	> 50 lbs
Lift/carry occasionally (0-2.6 hrs/day)						
Lift/carry frequently (2.7-5.3 hrs/day)						
Lift/carry constantly (5.4-8 hrs/day)						
How many total hours each day did the job involve the following?	< 2 hours	At least 2 hours	4 hours	About 6 hours	8 hours	Other
Stand and/or walk						
Sit						
PUSH AND/OR PULL ACTIVITIES (including operation of hand and/or foot control):						
Address all below:	YES	NO				
Upper extremities						
Lower extremities						
POSTURAL ACTIVITIES (cumulative, not continuous)						
How often are the following postural activities performed?	Never	Occasionally [0-2.6 hrs/day]	Frequently [2.7-5.3 hrs/day]	Constantly [5.4-8 hrs/day]		
Balance						
Climb (ramps, stairs, etc.)						
Climb (ladders, scaffolding, etc.)						
Stoop (bending from the waist)						
Crouch (bending both legs and spine)						
Crawl						
Kneel						
MANIPULATIVE ACTIVITIES (cumulative, not continuous)						
How often are the following postural activities performed?	Never	Occasionally [0-2.6 hrs/day]	Frequently [2.7-5.3 hrs/day]	Constantly [5.4-8 hrs/day]		
Reaching (overhead)						
Reaching (bench level)						
Fingering (fine motor manipulation)						
Handling (gross motor manipulation)						
Feeling (skin receptors, sensation, etc.)						
ENVIRONMENTAL ACTIVITIES (exposures to the following)						
Do the following environmental exposures exist?	YES	NO				
Noise						
Fumes (odors, dust, gases, etc.)						
Hazards (machinery, heights, etc.)						
Extreme hot or cold						
Humidity						
Vibration						

General remarks regarding additional physical job demands:

See next page

STEP 2: Certification by Department Head *(continued)* This section is required to be completed or the form will be invalid.

Employer Reported Mental Job Demands			
TRAINING AND SUPERVISORY ACTIVITIES			
Address all below:	YES	NO	Comment
Does this job require the applicant to supervise others?			
Does this job require the applicant to work independently without more than ordinary supervision (once the job is learned)?			
CONCENTRATION AND PERSISTENCE ACTIVITIES			
Address all below:	YES	NO	Comment
Does this job require sustained attention and concentration?			
Does this job require more than simple decision-making?			
SOCIAL INTERACTION ACTIVITIES			
Address all below:	YES	NO	Comment
Does the job involve interaction with the general public?			
Does the job involve interaction with co-workers?			

General remarks regarding additional mental job demands:

See next page

STEP 2: Certification by Department Head *(continued)* This section is required to be completed or the form will be invalid.

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

Department Head Signature ______________________________ Today's Date ____/____/____

Do not print or type name

See next page

STEP 3: Certification by Fiscal Officer

This section is required to be completed or the form will be invalid.

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

___ — ___ — ____

Authorized Signature ______________________ Today's Date ___/___/______

Do not print or type name

OPERS