

Ohio Department of Medicaid  
**DISABILITY SUPPLEMENTAL INFORMATION**

Employee's Name	
Claim Number	State of Ohio User ID
Agency	Payroll#
Information is for: <input type="checkbox"/> Extension <input type="checkbox"/> Reinstatement      NEW Date Last Worked _____ <input type="checkbox"/> Part-Time              Part-Time Schedule _____	
Date Employee ACTUALLY Returned to Work	
Agency Recommendation: <input type="checkbox"/> Approval <input type="checkbox"/> Disapproval <input type="checkbox"/> Doctor Review (send PD)	
Reason for disapproval or doctor review:	
Allow light/modified duty: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, temporary modification that can be made to job:	
Comments:	
Agency Contact	Phone Number
Appointing Authority or Designee Signature	Date