



## REPORT BY EMPLOYER (for a Disability Benefit Applicant)

**Applicant:** Please provide this form and the envelope marked "Report by Employer" to your most recent Ohio public employer.

**Employer:** Please return this completed form and official job description to STRS Ohio in the envelope provided.

Applicant \_\_\_\_\_ STRS Ohio account no.  
or Social Security no. (last four digits) \_\_\_\_\_  
Employer \_\_\_\_\_ County \_\_\_\_\_

The information requested in this report will assist the State Teachers Retirement Board in its consideration of the disability application for the above member. We appreciate your prompt response.

A member who was under contract when granted disability benefits and who has not resigned is on leave of absence from the position during the **first five years** on disability benefits. Disability benefit recipients are subject to periodic examinations. If such examination reveals that the recipient is capable of resuming the service from which he or she was found disabled, disability benefits are terminated. If benefits are terminated by the Retirement Board within the five-year period, the employer must restore the member to the same or to a similar position and salary.

### Section 1 — Certification by Employer

To be completed by treasurer, payroll director or fiscal officer.

This is to certify that \_\_\_\_\_  
Member's name  
was/is an employee of \_\_\_\_\_  
Employer

Current payroll status:

- |  |   |
|--|---|
| <input type="checkbox"/> Full time                             | <input type="checkbox"/> Receiving workers' compensation benefits (list |
| <input type="checkbox"/> Part time (list schedule) _____       | starting date) _____  |
| <input type="checkbox"/> Paid FMLA/sick leave since _____      | <input type="checkbox"/> Voluntary separation effective _____           |
| <input type="checkbox"/> Unpaid FMLA/sick leave since _____    | <input type="checkbox"/> Involuntary separation effective _____         |
| <input type="checkbox"/> Paid administrative leave since _____ | <input type="checkbox"/> Other _____                                    |

Please provide the following last dates of service and compensation:

- Last day this member was actually in the classroom/school (list date or still working): \_\_\_\_\_
- Number of sick or other leave days this member has remaining: \_\_\_\_\_
- If known, list the last date for which the member will be compensated (date worked or date for which sick leave was/will be used): \_\_\_\_\_
- The exact final date of compensation is not known; however, this member currently has \_\_\_\_\_ days of personal and/or sick leave available.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Title \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_  
Area code

(continued)



## Section 2 — Report of Employment by Employee's Supervisor

STRS Ohio provides disability benefits to an applicant who is no longer capable of performing his or her most recent job duties. In order to make this determination, STRS Ohio requires a copy of the applicant's most recent official job description. If this applicant's position has requirements not listed in the official job description, please list extra contracted duties below. Please **enclose a copy of the most recent official job description** to avoid a delay in the completion of this application.

Official job title the applicant last performed: \_\_\_\_\_

Position level (e.g., elementary, middle, high school, college): \_\_\_\_\_

Position grade level and subject (e.g., first grade, ninth-grade English, economics professor): \_\_\_\_\_

Description of job duties the applicant last performed: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In what ways does the applicant's performance of duties show probable disability for further service?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does the job require any special working condition or physical demands such as lifting/kneeling? If so, please specify (pounds lifted, frequency of kneeling, use of stairs, etc.).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please describe any accommodations made under the Americans with Disabilities Act.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Applicant's absence (current school year) \_\_\_\_\_ days.

Applicant's absence (previous school year) \_\_\_\_\_ days.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Title \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Area code