

**Resolution 2023-209**

**A Resolution Approving 80 Hours of Injury Leave for David Ratliff**

The Board of Trustees of Franklin Township, Franklin County, Ohio, met in person in a Regular Meeting at 12:00 p.m. on Thursday, September 21, 2023.

*The trustee marked below made a motion for the adoption of the following Resolution:*

*Fleshman*

*Leezer*

*Horn*

**BE IT RESOLVED** by the Board of Trustees of Franklin Township, Franklin County, Ohio, that the Board approves 120 hours of Injury Leave, beginning August 30, 2023, through September 20, 2023, for David Ratliff, per the employee's MOU.

**BE IT FURTHER RESOLVED** that this Resolution shall be in full force and effect immediately upon its adoption.

*The following trustee marked below seconded the motion:*

*Fleshman*

*Leezer*


*Horn*

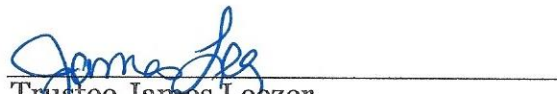
*Roll was called for the adoption of the Resolution, and the vote was as follows:*

Fleshman:  YES/  NO

Leezer:  YES/  NO

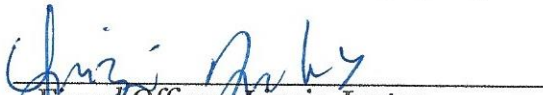
Horn:  YES/  NO

  
Trustee John Fleshman

  
Trustee James Leezer

  
Trustee Ralph Horn

*Attested to on this 21st day of September 2023,*

  
Fiscal Officer, Linzie Justus

*Adopted: September 21<sup>st</sup>, 2023*



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Sedgwick Ohio 5

Bureau of Workers' Compensation

Physician's Report of Work Ability (MEDCO-14)

Instructions:

- Use this form to provide detailed information about the injured worker's ability to work. Add comments to Section 4 or attach additional information as necessary. BWC uses the information to support a request for temporary total compensation.
- The treating physician must submit this form each time they see the injured worker unless they:
  - o Have been awarded permanent and total disability.
  - o Have returned to work without restrictions within seven days of the injury.
  - o Are being treated after the treating physician has released them to their former position of employment (i.e., full duty job) held on the date of injury without restrictions.
- While you may use an equivalent physician-generated document (e.g., office notes, treatment plan) to the MEDCO-14, it must contain, at a minimum, the required data elements. If you've previously submitted equivalent data, indicate the date of the report on the form (e.g., 5/15/2021, office note).

Note: Physician assistants and nurse practitioners may complete this form; however, they may only certify temporary disability for the first six weeks after the date of injury. Subsequent periods of temporary disability require a co-signature by the treating physician.

- Fax form to the managed care organization if the employer is state-funded or to the employer if self-insured.
- Important: Failure to provide complete information may delay compensation payments to the injured worker.

Injured worker name RATLIFE, DAVID, A.		Claim number [REDACTED]	Date of injury 05/15/2023
Date of last appointment/examination 06/28/2023	Date of this appointment/examination	Date of next appointment/examination 07/20/2023	
<b>Submission type (Select one of the options below.)</b>			
<input type="checkbox"/> Initial MEDCO-14. Proceed to Section 2. <input type="checkbox"/> Subsequent MEDCO-14, no changes. Proceed to Section 6. <input checked="" type="checkbox"/> Subsequent MEDCO-14, with changes. Check the appropriate box "Reporting changes from the last evaluation" or "No changes" in each section.			
<b>Job description and work status</b>			
<input checked="" type="checkbox"/> Reporting changes from last evaluation <input type="checkbox"/> No changes • Have you reviewed the injured worker's job description? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No o If yes, who provided the job description? <input checked="" type="checkbox"/> Injured worker <input type="checkbox"/> Employer <input type="checkbox"/> MCO/BWC. • Does the injured worker have any physical or health restrictions related to the allowed conditions in the claim on the date of this exam? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No o If yes, are the restrictions: <input type="checkbox"/> Permanent? <input checked="" type="checkbox"/> Temporary? o If no, check the box to indicate the injured worker is released to return to full duty as of the date of this exam. <input type="checkbox"/> Proceed to Section 6. • If there are restrictions, can the injured worker return to their full duty job held on the date of injury as of the date of this exam? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No o If yes, Proceed to Section 6. o If no, provide date restrictions began '6 / 28 / 23' and estimated full duty return-to-work date '10 / 21 / 23'. Proceed to Section 3.			
<b>Disability Information</b>			
<input checked="" type="checkbox"/> Reporting changes from last evaluation <input type="checkbox"/> No changes Complete the chart below for all work-related allowed conditions being treated:			
Narrative description of the work-related allowed condition	Site/Location if applicable	ICD code	Is the condition preventing full duty release to the job injured worker held on the date of injury?
ROTATOR CUFF TEAR	LEFT	S45.012A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
List all other conditions that impact treatment of the conditions listed above (e.g., co-morbidities or not yet allowed conditions).			