

**Resolution 2024-031**

**Approving 528 hrs. of Injury Leave for Eric Pierce**

The Board of Trustees of Franklin Township, Franklin County, Ohio, met in person in a Regular Meeting at 12:00 p.m. on Thursday, March 21, 2024. The trustee marked below made a motion for the adoption of the following Resolution:

**Leezer**                       **Fleshman**                       **Blevins**

**BE IT RESOLVED** by the Board of Trustees of Franklin Township, Franklin County, Ohio, that the Board approves 528 hours (22 days) of injury leave for employee Eric Pierce for the period 01/20/2024-03/23/2024, per Article 34 of the employee's collective bargaining agreement.

**BE IT FURTHER RESOLVED** that all formal actions of this Board concerning and relating to the adoption of this Resolution were passed in an open meeting of this Board and that all deliberations of this Board and any of its committees that resulted in such formal action, were in meetings open to the public, in compliance with all legal requirements including Section 121.22 of the Ohio Revised Code.

**BE IT FURTHER RESOLVED** that this Resolution shall be declared an emergency and shall be in full force effective immediately upon its adoption.

*The following trustee marked below seconded the motion:*

**Leezer**                       **Fleshman**                       **Blevins**

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

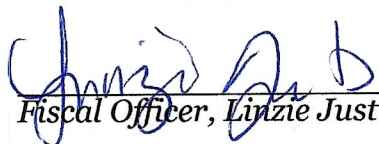
**Leezer:**  YES/  NO      **Fleshman:**  YES/  NO      **Blevins:**  YES/  NO

  
\_\_\_\_\_  
Trustee James Leezer

  
\_\_\_\_\_  
Trustee John Fleshman

  
\_\_\_\_\_  
Trustee Mike Blevins

Adopted on March 21, 2024  
Attested to on this 21st day of March 2024

  
\_\_\_\_\_  
Fiscal Officer, Linzie Justus



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:
  - Have been awarded permanent and total disability.
  - Have returned to work without restrictions within seven days of the injury.
  - 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 <u>Eric Pierce</u>		Claim number <u>63220020</u>	Date of injury <u>1-20-24</u>
Date of last appointment/examination <u>1/24/24</u>	Date of this appointment/examination <u>1/24/24</u>	Date of next appointment/examination <u>[redacted]</u>	
Submission type (Select one of the options below.)			
<input checked="" type="checkbox"/> Initial MEDCO-14. Proceed to Section 2. <input type="checkbox"/> Subsequent MEDCO-14, no changes. Proceed to Section 6. <input type="checkbox"/> Subsequent MEDCO-14, with changes. Check the appropriate box "Reporting changes from the last evaluation" or "No changes" in each section.			
Job description and work status		<input type="checkbox"/> Reporting changes from last evaluation <input type="checkbox"/> No changes	
1. Have you reviewed the injured worker's job description? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes, who provided the job description? <input type="checkbox"/> Injured worker <input type="checkbox"/> Employer <input type="checkbox"/> MCO/BWC 2. 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 type="checkbox"/> Yes <input type="checkbox"/> No If yes, are the restrictions: <input type="checkbox"/> Permanent? <input checked="" type="checkbox"/> Temporary? 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 If yes, Proceed to Section 6. If no, provide date restrictions began: <u>1/22/24</u> and estimated full duty return-to-work date: <u>2/19/24</u> Proceed to Section 3.			
Disability information		<input 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?
[redacted]	<u>[redacted]</u>		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
[redacted]	<u>[redacted]</u>		<input type="checkbox"/> Yes <input type="checkbox"/> No
[redacted]	<u>[redacted]</u>		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
[redacted]			<input type="checkbox"/> Yes <input type="checkbox"/> No
[redacted]			<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): <u>[redacted]</u>			

Injured worker name: Eric Pierce Claim number: [redacted] Date of injury: 1-20-24

Abilities, clinical findings, and recovery progression  
 Reporting changes from last evaluation  No changes  
 • Is the injured worker taking prescribed medication for the allowed conditions that may be a safety hazard?  Yes  No  
 • Dominant hand:  Right  Left  
 • Circle the injured worker's physical abilities for the activities in the chart below and provide comments as necessary.

Frequency scale		Strength level (lbs.)					Body side indicator	
N = Never		S = Sedentary	0-10	L = Left				
S = Seldom	0-1 hour	L = Light	0-20	R = Right				
O = Occasional	1-3 hours	M = Medium	0-50	B = Both				
F = Frequent	3-8 hours	H = Heavy	0-100					
C = Constant	8-9 hours	VH = Very heavy	>100					

Activity	N	S	O	F	C	Activity	N	S	O	F	C	Activity	N	S	O	F	C
Stand/Walk	N	S	O	F	C	Foot lift (10-20)	S	L	M	H	VH	Front/ lateral reach	L	R	B		
Climb stairs	N	S	O	F	C	Reach up (18-20)	S	L	M	H	VH	Overhead reach	L	R	B		
Squat/Kneel	N	S	O	F	C	Walk up (20-30)	S	L	M	H	VH	Wide flex/extension	L	R	B		
Crawl	N	S	O	F	C	Cherish (47-60)	S	L	M	H	VH	Grasp	L	R	B		
Twist	N	S	O	F	C	Overhead lift (50)	S	L	M	H	VH	Pinch manipulation	L	R	B		
Band/loop	N	S	O	F	C	Push/Pull	S	L	M	H	VH	Keyboarding	L	R	B		
	N	S	O	F	C	Carry	S	L	M	H	VH	Operate tool controls	L	R	B		

• Injured worker can work \_\_\_\_\_ hours per day and \_\_\_\_\_ hours per week.  
 • Are there any functional restrictions based only on the allowed psychological conditions?  Yes  No.  
 • If yes, describe any functional restrictions in comments below and reference the MEDCO-19 as needed.  
 • Provide your clinical and objective findings supporting your medical opinion. List barriers to return to work, reason(s) for delayed recovery, and proposed treatment plan (e.g., modalities, therapies, surgery), including estimated duration of each treatment or indicate if all or part of this information is in office notes (include date(s) of notes).  
 Comments:  
No work w/lf 2/12/24 [redacted]

Health and Behavioral Assessment: (HBA) evaluates cognitive, emotional, social, and behavioral barriers that might impact physical health problems and treatments which are associated with the allowed physical injury in the claim.  
 • Is the injured worker's recovery not progressing, or progressing slower than expected?  Yes  No  
 • Do cognitive, emotional, social, or behavioral barriers exist that may be interfering with expected healing?  Yes  No  
 Vocational rehabilitation is a voluntary program for an eligible injured worker who needs assistance to remain at work or return to work. Is the injured worker currently able to participate in a vocational rehabilitation program?  Yes  No

Maximum medical improvement (MMI) status:  Reporting changes from last evaluation  No changes  
 MMI is a treatment plateau (stable or well-stabilized) at which no fundamental functional or physiological change can be expected within reasonable medical probability, in spite of continuing medical or rehabilitative procedures. Has the work-related injury(s) or occupational disease reached MMI based on the definition above?  Yes  No  
 • If yes, give MMI date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_. Note: An injured worker may need supportive treatment to maintain his or her level of function after reaching MMI. So, periodic medical treatment may still be requested and, if approved, provided.

Treating physician's signature - mandatory (See exceptions at the top of the form.)  
 I certify the information on this form is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain payment as provided by BWC, or who knowingly accepts payment to which that person is not entitled, is subject to felony criminal prosecution and may be punished, under appropriate criminal provisions, by a fine or imprisonment or both.

Treating physician's name (Print name): [redacted] Address, city, state, nine-digit ZIP code: [redacted]  
 Treating physician's signature: [redacted]  
 BWC provider (PEACH) number: [redacted] Date: 1/22/24 Telephone number: [redacted] Fax number: [redacted]