Resolution 2024-054

A Resolution Approving 80 hrs. of Injury Leave for Troy Hale

The Board of Trustees of Franklin Township, Franklin County, Ohio, met in person in a Regular Meeting at 12:00 p.m. on Thursday, April 18, 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 80 hours of injury leave for employee Troy Hale for the period 04/07/2024-04/20/2024, per Article 24 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 April 18, 2024
Attested to on this 18th day of April 2024

Fiscal Officer, Linzie Justus

Received: 1/25/2024 8:25:00 AM.
ImageFax ID: 8344360
Sedgwick MCO 10005

Ohio | Bureau of Workers' Compensation

Physician's Report of Work Ability

Injured worker name: Troy Hale

Date of injury	Date of last appointment/examination	Date of this appointment/examination	Date of next appointment/examination
10-11-23		1-24-24	[redacted]

MEDCO-14 submission (Select one of the options below)

1
- ☐ I have never completed a MEDCO-14. *Proceed to section 2.*
- ☐ I have previously completed a MEDCO-14.
- ☑ I have previously completed a MEDCO-14, and all of the information remains the same. *Proceed to and complete section 8.*
- ☐ I have previously completed a MEDCO-14, and I am providing updates appropriately checking Yes or No on each section.

Employment/Occupation (Complete this section and proceed to section 3.)

2 Have you reviewed the description of the injured worker's job held on the date of injury (former position of employment)? Yes ☑ No ☐ (Updates Yes ☑ No ☐)
If yes - please indicate who (select all sources) provided the job description ☐ Injured worker ☐ Employer ☐ MCO ☐ BWC

Work status/Injured worker's capabilities

3A Does the injured worker have any physical or health restrictions related to allowed conditions in the claim? Yes ☐ No ☐ (Updates Yes ☑ No ☐)
If yes, are the restrictions: ☐ Permanent ☑ Temporary *Proceed to section 3B.*
If no, please check the box to indicate the injured worker is released to work as of the date of this exam. ☐ *Proceed to section 8.*

3B If there are restrictions, can the injured worker return to the full duties of his/her job held on the date of injury (former position of employment)? Yes ☐ No ☐
If yes, please check the box to indicate that the injured worker is released to work as of the date of this exam. ☐ *Proceed to section 8.*
If no, please indicate when the injured worker could not do the job held on the date of injury for this period of restricted duty.
Date: 10/24/23
Please estimate when the injured worker should be able to return to the job held on the date of injury for this period of restricted duty.
Date: 02/20/24 *Proceed to section 3C.*

3C Please indicate which of the activities listed below the injured worker can perform (even if the response to 3B is No.)
If the injured worker is not released to the former position of employment but may return to available and appropriate work with restrictions, please indicate the possible return to work date: ___/___/___
The injured worker can perform simple grasping with: ☐ Left hand ☐ Right hand ☐ Both
The injured worker can perform repetitive wrist motion with: ☐ Left hand ☐ Right hand ☐ Both
The injured worker's dominant hand is: ☐ Left ☐ Right
The injured worker can perform repetitive actions to operate foot controls or motor vehicles with: ☐ Left foot ☐ Right foot ☐ Both
If the injured worker is taking prescribed medications for the allowed conditions in this claim, can the injured worker safely:
*Operate heavy machinery: ☐ Yes ☐ No *Drive: ☐ Yes ☐ No *Perform other critical job tasks as defined by any source listed above in section 2: ☐ Yes ☐ No

Please indicate the following: N = Never O = Occasionally F = Frequently C = Continuously

Activity	N	O	F	C	Activity	N	O	F	C	Lifting/carrying	N	O	F	C	Pushing/pulling	N	O	F	C
Bend					Reach above shoulder					0 - 10 lbs.					0 to 25 lbs.				
Squat/kneel					Type/keyboard					11 - 20 lbs.					26 to 40 lbs.				
Twist/turn					Work with cold substances					21 - 40 lbs.					41 to 60 lbs.				
Climb					Work with hot substances					41 - 60 lbs.					61 to 100 lbs.				
										61 - 100 lbs.					100 + lbs.				

How many total hours can the injured worker work: ____ per week ____ per day?
In an eight-hour workday, how many total hours can the injured worker: Sit: ____ hours ☐ Continuously ☐ With break
Walk: ____ hours ☐ Continuously ☐ With break Stand: ____ hours ☐ Continuously ☐ With break
Does the injured worker have any functional restrictions based only on allowed psychological conditions? ☐ Yes ☐ No If Yes, please describe in space provided below. Note: If Yes is indicated please reference the MEDCO-16 as needed.
Additionally, in this space, please provide any additional information addressing the injured worker's capabilities and/or job accommodations which may not be addressed above.

Patient waiting on Physical therapy approval.
Continue off work.

Injured worker name: Trov Hale [redacted] Date of injury: 10-16-23

Disability information If 3B above is "NO" or dates updated - all 4A fields, including site/location if applicable must be completed. (Updates Yes ☐ No ☐)

Complete the chart below and furnish the narrative description of the diagnosis(es), site/location, if applicable, and International Classification of Diseases (ICD) code(s) for the condition(s) being treated due to the work-related injury/disease. Please indicate if the condition is preventing the injured worker from returning to job duties he/she held on the date of injury.

	Narrative description of the work-related allowed condition	Site/location if applicable	ICD-10 code	Is the condition preventing full duty release to the job injured worker held on the date of injury?
4A	[redacted]			Yes ☐ No ☐
	[redacted]			Yes ☑ No ☐
	[redacted]			Yes ☐ No ☐
	[redacted]			Yes ☑ No ☐
4B	List all other relevant conditions that impact treatment of the conditions listed above (e.g., co-morbidities or not yet allowed conditions).			Yes ☐ No ☐

Clinical findings: You can reference office notes in lieu of writing clinical findings below. (Updates Yes ☑ No ☐)

5 The injured worker is progressing: ☐ As expected ☐ Better than expected ☐ Slower than expected
Provide your clinical and objective findings supporting your medical opinion outlined on this form. List barriers to return to work and reason, for the injured worker's delay in recovery.

See recent note

Maximum medical improvement (MMI)

6 MMI is a treatment plateau (static 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 ☐ (Updates Yes ☐ No ☑)
If yes, give MMI date: ___/___/___. If no, please provide the proposed treatment plan, including estimated duration of each treatment (attach additional sheet if necessary):

Note: An injured worker may need supportive treatment to maintain his or her level of function after reaching MMI. Thus, periodic medical treatment may still be requested and provided.

Vocational rehabilitation

7 Vocational rehabilitation is an individualized and voluntary program for an eligible injured worker who needs assistance in safely returning to work or in retaining employment. This program can be tailored around an injured worker's restrictions and may provide job seeking skills or necessary retraining. Is the injured worker a candidate for vocational rehabilitation services focusing on return to work? (Updates Yes ☐ No ☑)
Yes ☐ No ☐ If no, please explain why and provide your recommendations to help the injured worker return to employment.

Treating physician signature - mandatory

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.

8 [redacted] Address, city, state, nine-digit ZIP code: [redacted]
Signature
BWC provider (7 each) number
Telephone number