

Section C: Training Program

Have you tried to enroll in any training or apprenticeship program(s)? yes no
 If yes, indicate the training program(s) in which you had enrolled as well as whether or not it was successfully completed:

Program name: _____ Successfully completed? yes no

Are you receiving Worker's Compensation? yes no

If yes, what benefits are you currently receiving:

Medical expenses Temporary total Temporary partial Permanent total Permanent partial

Are you receiving Social Security disability payments? yes no

Section D: Earned Income Report

Please state your earned income (wages, self-employed compensation, tips) in each complete tax (calendar) year since you retired. If you have been retired for more than five years, report only your earned income for the last five complete years. Also report your primary employer, job title and the duties performed.

Year	Earned Income*	Employer (list only primary employer)	Job Title	Duties Performed
20	\$			
20	\$			
20	\$			
20	\$			
20	\$			

* Do not report spouse's income, interest, dividends or income from sources other than wages, self-employed compensation, tips, etc.

Section E: Member signature and acknowledgement

I, the member described in Section A of this Disability Reconsideration Application, represent that I am the person herein described; it is my will and intent to apply for a reconsideration of disability benefits under Chapter 742 of the Ohio Revised Code; I understand that this application will not be processed until received by OP&F, and determination of my eligibility to file this application has been determined by OP&F; and that the statements made herein are true and correct.

I certify, under penalties of perjury, that I have reviewed this OP&F application for disability benefits and all statements and documents supporting my application are truthful and accurate. I understand that if the statements and/or documents supporting the application are proven to be false it may result in the termination of any benefits that may be payable to me, as well as possible civil and criminal penalties.

Member's signature:

Date of signature:

Section F: Notary public requirement

The notary public in good standing must sign in the space provided in this section and affix their seal.

State of _____, County of _____, ss:

The foregoing *Disability Reconsideration Application* was acknowledged before me by the member named in the foregoing Section A, this _____ day of _____, 20_____.

Affix Seal here

Notary's signature:

Print name:

My commission expires: