THE OHIO STATE UNIVERSITY

Integrated Disability

Pre-reinstatement Hearing Waiver

SECTION 1: REQUIRED EMPLOYEE INFORMATION

I ______________________________ ______________________________
Employee's Full Name OSU Employee ID# (required)

understand that the outcome of my return to work evaluation performed by University Health Services

determined I was not able to meet the essential functions of my former position as

______________________________ (attached).

As a Classified Civil Service employee, I agree to waive my right to a pre-reinstatement hearing.

SECTION 2: AUTHORIZATION

I understand I am still eligible to be reinstated to a position similar to the one I last held two (2) years from the effective date of my disability separation.

______________________________ ______________________________
Employee Signature Date

Keep a copy of this form for your personal records.

For additional information, contact the Office of Human Resources Customer Service Center at:
614-292-1050, **800-678-6010**, Fax: **614-292-6235**, service@hr.osu.edu or **hr.osu.edu**.

Return completed form to: The Ohio State University, Office of Human Resources, Integrated Disability, 1590 North High Street, Suite 300, Columbus, OH 43201-2190.