THE OHIO STATE UNIVERSITY

Request for Placement on Voluntary Disability Separation

SECTION 1: REQUIRED EMPLOYEE INFORMATION

I, _____ _____
Employee's Full Name OSU Employee ID#

understand that I have exhausted my twelve (12) -week Family Medical Leave entitlement. As a Classified Civil Service employee, I would like to request a voluntary disability separation.

SECTION 2: AUTHORIZATION

I understand that under this arrangement, I am eligible to be reinstated to a position, similar to the one I last held, within a reasonable period of time after making a written application for such reinstatement to the Office of Human Resources, Benefits, accompanied by a statement from my physician indicating that I have recovered from my disability. My eligible reinstatement period will be for two (2) years from the effective date of my voluntary disability separation.

By signing this agreement, I understand that I am waiving my rights to a disability separation hearing as a Classified Civil Service employee, understanding that this is not an involuntary separation of employment, but rather a voluntary disability separation of employment.

_____ _____
Employee Signature Date

Return completed form to:

The Ohio State University, Office of Human Resources
1590 N. High Street, Suite 300, Columbus, OH 43201-2190
Attention: Integrated Absence Management & Vocational Services (IAMVS)