Municipality of Monroeville
Short Term Disability
Employer/ Employee Statement

TO BE COMPLETED BY EMPLOYEE

Employee's Full Name:	Social Security No:	Phone No:	Birthdate:	Sex:

Address:	City:	State:	Zip Code:

Is your disability work related? _____Yes _____No	Have you filed a Workers Compensation Claim? _____Yes _____No
Do you intend to file a Workers Comp. Claim? _____Yes _____No	Last active day at work:
Date you became unable to work because of disability:	Date you returned or expect to return to work:

____ Accident. When and where did it happen? _____Illness. When did you first notice the nature of your Disability?	How does your disability prevent you from working?	Pregnancy: Expected delivery date: _____ Actual delivery date: _____ Type of delivery: _____ Vaginal _____ C-Section

Acknowledgment

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief.

Signature: Date:

TO BE COMPLETED BY ATTENDING PHYSICIAN

1. Diagnosis

A. Diagnosis	ICDA Classification:
B. Symptoms	C. Objective Findings Height: Weight: B/P:

2. Pregnancy (if applicable)

A. Expected Date of Delivery:	B. Actual Date of Delivery:	C. Type of Delivery __Vaginal ___ C-Section

D. Significant complications, if any:

3. History

A. Date you recommended the patient stop work:	B. When did symptoms appear or accident happen?

C. Has patient ever had the same or similar condition? If yes, when?

D. Is this condition related to the patient's employment?	E. Did you complete a worker's compensation claim form?

TO BE COMPLETED BY ATTENDING PHYSICIAN (continued)

4. Treatment

A. Date of first visit:	B. Date(s) of subsequent visits:	C. Date of most recent visit:

D. Planned course and duration of treatment (include surgery and medications, if any):

5. Level of Functional Impairment

A Describe the patient's mental and cognitive limitations, if any.

B. In a work day given two breaks and a meal break, your patient can:

Lift (in pounds) ___1-10 ___11-20 ___21-50 ___51-75 ___75+

Carry (in pounds) ___1-10 ___11-20 ___21-50 ___51-75 ___75+

	Total Hours	With positional change
Sit	8 7 6 5 4 3 2 1	(hrs)_____
Stand	8 7 6 5 4 3 2 1	(hrs)_____
Walk	8 7 6 5 4 3 2 1	(hrs)_____
Alternately Sit/Stand	8 7 6 5 4 3 2 1	(hrs)_____

Bend/stoop: ___ Never ___Occasionally ___Frequently

C. Is this patient competent to endorse checks and direct the use of proceeds? ____ Yes ____No

6. Hospitalization (if applicable)

A. Date admitted:	B. Date discharged:	C. Reason:

D. Name of hospital:

7. Prognosis

A. Since onset of symptoms, the patient's condition has: ___Improved ___Not changed ___Regressed

B. When do you anticipate the patient can return to work? Date: _____ Unable to determine, follow up in _____weeks _____never

8. Physician Information (Please type or print)

Name of physician completing this form:		Phone Number: ( )	
Specialty:	Tax ID No.	Fax Number: ( )	
Address:	City:	State:	Zip Code

Acknowledgment

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief.

Signature: Date:

AUTHORIZATION TO OBTAIN INFORMATION

I Authorize These Persons having any records or knowledge of me or my health:

- Any physician, medical practitioner or health care provider.
- Any hospital, clinic, pharmacy or other medical or medically related facility or association.
- Any insurance or annuity company.
- Any employer or plan sponsor.
- Any organization or entity administering a benefit program or an annuity program.
- Any educational, vocational or rehabilitational organization or program.
- Any consumer reporting agency, financial institution, accountant, or tax preparer.
- Any government agency (for example, Social Security Administration, Public Retirement System, etc.)
- The Municipality of Monroeville designated Work Injury/Disability Coordinator.

To Give This Information

Charts, notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing and test results. Prognosis and treatment of any physical or mental condition including:

- Any disorder of the immune system, including HIV, Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes.
- Any communicable disease or disorder.
- Any psychiatric or psychological condition, including test results, but excluding psychotherapy notes. Psychotherapy notes do not include a summary of diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date.
- Any condition, treatment, or therapy related to substance abuse, including alcohol and drugs
- Any non-medical information requested about me, including such things as education, employment history, earnings or finances, or eligibility for other benefits including retirement benefits and retirement plan contributions.

I acknowledge that I have read the authorization. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

_____ _____

Name (Please Print) Social Security Number

_____ _____

Signature Date