PRINCETON UNIVERSITY
INSTRUCTIONS FOR SHORT TERM TEMPORARY DISABILITY

PATIENT INSTRUCTIONS:
STEP 1: APPLYING FOR TEMPORARY DISABILITY BENEFITS

1. Complete the Application for Temporary Disability Benefits and submit to Occupational Health Services via fax at (609)258-0976. Your signature is required at the bottom of the form.
2. Your treating provider will need to complete the Request for Medical Information from Health Care Provider. Your signature is required to authorize your treating provider to release the requested information to Princeton University Occupational Health Services.
3. You or your doctor may fax the completed forms to Occupational Health at (609)258-0976. They may also be mailed to: Occupational Health, Princeton University, Washington Road, McCosh Health Center, Princeton, NJ 08544-1044.
4. Notify your supervisor of your absence as soon as possible and keep them informed on a regular basis of your expected date of return to work. At no time should you feel required to discuss your medical condition with your supervisor or Human Resources.
5. Failure to provide medical documentation within 2 weeks of the initial date of absence will result in the determination that the STD is not medically supported, by Occupational Health Services; and may result in a delay in benefits and/or discipline up to and including termination.

This form is not used to report a work-related injury or illness. If you have been injured at work, please contact Occupational Health at (609)258-5035.

STEP 2: PROVIDING UPDATES WHILE OUT ON TEMPORARY DISABILITY

1. Once your disability is approved you will receive a written notification from Human Resources, along with additional Request for Medical Information from Health Care Provider forms to be used to provide updates from your treating provider every two weeks to four weeks.
2. It is your responsibility to make sure that your treating provider submits the periodic updates promptly every two to four weeks. Failure to do so will result in the determination that the STD is not medically supported, by Occupational Health Services; and may result in denial of continued STD benefits support, a delay in your pay or termination of your temporary disability benefits.

STEP 3: RETURNING TO WORK FROM A TEMPORARY DISABILITY

1. You must be cleared by Occupational Health prior to returning to work. Please call Occupational Health at (609)258-5035 to schedule a return to work appointment before your return date. Please advise of any work restrictions as soon as you become aware of this need.
2. Notify your supervisor of your anticipated return to work.

For more information on Princeton University’s Temporary Disability policy, please call Human Resources at (609)258-3302 or visit http://www.princeton.edu/hr/benefits/disability/std/

HEALTH CARE PROVIDERS – PLEASE NOTE:
Under the New Jersey Temporary Disability Law (N.J.A.C 12:18 – 1.6), medical practitioners are prohibited from charging a fee for completing forms issued by the Division of Temporary Disability Insurance or any private insurance carrier requesting medical information associated with any initial or continued claim for benefits.
APPLICATION FOR TEMPORARY DISABILITY BENEFITS

NAME ___________________________ EMPLOYEE ID _______________ DATE OF BIRTH __________________

STREET ADDRESS ___________________________ CITY, STATE, ZIP __________________

MOBILE # ___________________ HOME # __________ DEPT __________ SUPERVISOR ______________

What was the date of the last day you worked before this present disability began? ________________________________

Did you work a full day? ☐ Yes ☐ No If no, explain __________________________________________________________

What was the date of the first day you were unable to work because of this disability? __________________________

(even if this is a Saturday, Sunday, holiday or regular day off)

If now recovered, what was the date of the first day on which you were able to resume work? ______________________

Were you injured at work? ☐ Yes ☐ No If yes, explain ______________________________________________________

Have you filed, or do you intend to file a Workers’ Compensation claim? ☐ Yes ☐ No Date of Injury ________________

Please provide the following information regarding the health care provider who is treating you for this disability:

Name of Physician ___________________________ Specialty __________________ Phone number __________________

Address of Physician ______________________________________________________________________________________

SECOND EMPLOYER / SELF EMPLOYMENT INFORMATION

Are you or were you working at any other job during the period in which you are applying for disability benefits? ☐ Yes ☐ No

Are you receiving or have you received wages, salary, or vacation pay from another employer during the period for which you are applying for disability benefits? ☐ Yes ☐ No

Are you receiving or claiming disability benefits under another employer? ☐ Yes ☐ No

Please list any employers other than Princeton University for which you are currently working or have worked during the past twelve months, including part time or temporary employment.

Name of Second Employer __________________________________________________________

Street Address __________________________________________ City, State, Zip ______________

Worked from _______________ to _______________ Phone __________________

Certification and Signature:

I was unable to work during the period for which benefits are claimed and hereby certify that all the statements made by me on this form are true. I know that the law provides penalties for false statements made to obtain benefits. I authorize and request that information regarding my medical condition and impairments that are relevant to my ability to perform my job may be furnished to Princeton University Occupational Health. I give permission for a health care professional from Princeton University to contact and speak with my healthcare provider to discuss my medical condition, treatment, and/or ability to perform my job, and hereby give my permission for release of any medical information required by Princeton University for the processing of my temporary disability benefits. I understand that all information furnished will be treated in confidence by Princeton University and will not be released unless required by law.

SIGNATURE: __________________________________________ DATE: __________________________

*Fax completed application to Occupational Health Services at (609)258-0976

Updated 2/4/2020 VG
Health Care Provider Request for Medical Information *

Employee’s Name: ____________________________________   DOB: __________________________

5. Please list any impairments and functional limitations which your patient may have:
____________________________________________________________________________________
____________________________________________________________________________________

6. Please review the essential functions of the job description and job specific tasks, (enclosed).
   a. After review and consideration of the essential functions of the job, does their condition allow work with or without accommodations? __________
   b. If your patient is on leave, please provide the estimated time frame for return to work with or without accommodations. ________________________________

7. If your patient requires job restrictions or accommodations in order to perform the essential functions of their job, please outline these requirements below. Include the duration of restrictions or accommodations needed to permit the patient to perform the essential functions of their job.
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

I hereby acknowledge and verify by my signature that the information provided is accurate, complete, and current.

Health Care Provider’s Signature _____________________________________________ Date __________

Print Health Care Provider’s Name _________________________________________________

State/License # _____________________________________________________________________

Address ___________________________________________________________________________

Phone __________________________________ Fax ________________________________

*The Request for Medical Information form is intended for use with all Short Term Disability and Accommodation medical determinations.
Health Care Provider Request for Medical Information *

Date: ______________________  PUID#: ______________________
Employee’s Name: ___________________________ DOB: ________________

Dear Health Care Provider,

Your patient is employed at Princeton University. The mission of Occupational Health Services is to ensure employees remain engaged in the workforce and are able to safely perform their jobs. We require additional and specific medical information to determine if this employee is able to perform the essential functions of the job with or without accommodations. Please provide complete, specific and legible answers to the questions below. Thank you for assisting your patient and Princeton University Occupational Health Services’ clinical staff.

I authorize my treating provider to release the requested information to Princeton University Occupational Health Services’ clinical staff.

Employee’s signature: ___________________________ Date: __________________

1. Patient’s diagnoses and onset of diagnoses:

________________________________________________________________________
________________________________________________________________________

2. How long have you been treating your patient?

________________________________________________________________________

3. Please list all scheduled testing and treatment plans associated with this condition:

________________________________________________________________________
________________________________________________________________________

4. Include a list of all medications prescribed by you and all the patient’s providers.

________________________________________________________________________
________________________________________________________________________

*The Request for Medical Information form is intended for use with all Short Term Disability and Accommodation medical determinations.