

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, to be submitted with your first medical certificate only. Your **signature is required** at the bottom of this form.
2. Complete and sign the top portion of the Medical Certificate, and have your treating provider complete the remainder of the Medical Certificate and sign.
3. You or your provider may fax the completed forms to Occupational Health at (609) 258-0976. They may also be mailed to UHS Occupational Health, Princeton University, Washington Road, McCosh Health Center, Princeton, NJ 08544-1044.
4. **Notify your supervisor of your absence due to a medical condition 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 information within 2 weeks of the initial date of absence 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 call Occupational Health at (609) 258-5035.

STEP 2: PROVIDING UPDATES WHILE OUT ON TEMPORARY DISABILITY

1. Once your disability is approved you will receive written notification from Human Resources, along with additional follow up medical certificate form to be used to provide updates from your health care provider **every two weeks to four weeks.**
2. **It is *your* responsibility to make sure your health care provider completes the follow up medical certificate forms promptly and submit them to Occupational Health every two to four weeks. Failure to do so may result in 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 on or before your return date. Please advise Occupational Health 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 <https://hr.princeton.edu/myhr/policies/short-term-disability>

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.

PRINCETON UNIVERSITY
APPLICATION FOR TEMPORARY DISABILITY BENEFITS

(To be included with medical certificate)

TO BE CONSIDERED FOR TEMPORARY DISABILITY BENEFITS, THIS APPLICATION AND THE MEDICAL CERTIFICATE MUST BE RETURNED TO OCCUPATIONAL HEALTH, PRINCETON UNIVERSITY, WASHINGTON ROAD, MCCOSH HEALTH CENTER, PRINCETON, NJ 08544-1004. PHONE (609) 258-5035, FAX (609) 258-0976.

NAME _____ **EMPLOYEE ID** _____

STREET ADDRESS _____ **CITY, STATE, ZIP** _____

HOME PHONE () _____ **MOBILE PHONE ()** _____ **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 _____ Phone number _____ Fax number _____

Address of Physician _____

Date you were first treated by this physician for this condition _____

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 other Employer _____

Street Address _____ City, State, Zip _____

Worked from _____ date to _____ date 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:** _____

CONFIDENTIAL

**PRINCETON UNIVERSITY
MEDICAL CERTIFICATE**

Return completed form via fax or mail to:

Occupational Health, Princeton University, McCosh Health Center
Washington Road, Princeton NJ 08544-1044
Phone: 609-258-5035 Fax: 609-258-0976

TO BE COMPLETED BY THE EMPLOYEE:

NAME: _____ HOME PHONE: _____ MOBILE PHONE: _____

HOME ADDRESS: _____
Street City State Zip

Employee ID: _____ DEPARTMENT: _____ SUPERVISOR: _____

I hereby give my permission for release of any medical information required by Princeton University and their agents for the processing of my temporary disability benefits.

SIGNATURE: _____ DATE: _____

TO BE COMPLETED BY THE HEALTH CARE PROVIDER:

Patient's condition is the result of: Illness Injury Pregnancy Mental/Nervous Condition

If pregnancy, what is the expected date of delivery: Month _____ Day _____ Year _____

Is condition due to an illness or injury that is work related? Yes No

FIRST DATE PATIENT UNABLE TO WORK: _____

DIAGNOSIS (including any complications):

Primary Diagnosis _____ Secondary Diagnosis(es) _____

Subjective Symptoms _____

Physical Findings _____

Test _____ Date _____ Results _____

Remarks _____

TREATMENT

Date of onset of this condition _____ How often is patient seen/treated? _____ Date of next visit _____

Has patient been referred to any other physician? No Yes If yes, name: _____ Specialty: _____

Nature of treatment for this condition (including surgery/medications) _____

Was patient hospitalized for this condition? Yes No If yes, date admitted _____ Date discharged _____

Was surgery performed? Yes No If yes, Date _____ Type of Surgery/ Procedure _____

Progress (please check one) Recovered Improved Unchanged Retrogressed

IMPAIRMENT

What is the psychiatric impairment (if applicable)?

- Inadequate information to make an assessment.
- Essentially good functioning in all areas. Occupationally and socially effective.
- Slight difficulty in occupational functioning, but generally functioning well. Has some meaningful interpersonal relationships.
- Moderate impairment in occupational functioning. Limited in performing some occupational duties.
- Major impairment in several areas—work, family relations. Avoidant behavior, neglects family, is unable to work.
- Inability to function in most areas.

What are the patient's current physical limitations? (Princeton University makes every effort to offer light duty when possible)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> No limitation of functional capacity, no restrictions | <input type="checkbox"/> No reaching arm R L above shoulder | May stand/walk: | May sit: |
| <input type="checkbox"/> No bending to floor level | <input type="checkbox"/> No Lifting > 20 lb, 30 lb, 50 lb, 75 lb, 100 lb | <input type="checkbox"/> 1-4 hours/day | <input type="checkbox"/> 1-4 hours/day |
| <input type="checkbox"/> No twisting to transfer object | <input type="checkbox"/> No Carrying > 20lb, 30 lb, 50 lb, 75 lb, 100 lb | <input type="checkbox"/> 4-6 hours | <input type="checkbox"/> 4-6 hours/day |
| <input type="checkbox"/> No squatting below chair level | <input type="checkbox"/> No use of R L Hand | <input type="checkbox"/> 6-8 hours | <input type="checkbox"/> 6-8 hours/day |
| <input type="checkbox"/> No climbing ladder/catwalk | <input type="checkbox"/> No keyboard/mouse use | <input type="checkbox"/> No limit | <input type="checkbox"/> No limit |
| <input type="checkbox"/> No climbing more than one flight of stairs | | | |

If physical or psychiatric limitations exist, how long do you feel limitations will last? _____

DATE ABLE TO RETURN TO WORK WITH RESTRICTIONS: _____

ANTICIPATED RETURN TO FULL DUTY WORK DATE: _____

I hereby certify that the above statements, in my opinion, truly describe the claimant's disability and the estimated duration thereof. Upon request, I will provide or be willing to discuss additional medical information required by Princeton University for the processing of the above employee's temporary disability benefits.

PHYSICIAN'S NAME _____ PHYSICIAN'S SIGNATURE (Required) _____

ADDRESS AND PHONE _____