Claim for Benefits

Instructions: Please complete all sections thoroughly and mail original to:

Tompkins County Personnel Department
125 East Court Street
Ithaca, NY 14850

(607) 274-5526 phone
(607) 274-5401 fax

To be completed by Physician ONLY

Tompkins County is eager to work with employees and their physicians to facilitate a return to full-time or part-time work, with or without reasonable accommodation. Your participation in this process is critical and welcome. Your recommendations for a successful and speedy return-to-work will be greatly appreciated. Thank you.

This patient has authorized the release of medical information regarding the following disability claim.

1. Claimant's Name: _____ _____
   first last
2. Claimant's Symptoms: _____
   _____
3. Medical Findings and Diagnosis: _____
   _____
4. Is surgery indicated? ☐ yes ☐ no
   If yes, what kind of surgery? _____
   _____
   What date? ____/____/____ _____
5. Record of medical treatment:

	month	day	year
a. Date you first treated for this injury/illness and the related absence from work:			
b. Most recent treatment date:			
c. Date claimant unable to perform regular duties because of this injury/illness:			
d. Date claimant can perform regular duty:			

○ Is claimant able to perform light duty? ☐ no ☐ yes If yes, when? ____/____/____

○ Please suggest restrictions or accommodations of light duty (job description provided upon request):
_____
_____

○ Is claimant able to work part-time? ☐ yes ☐ no
If yes, how many hours per week? _____ hrs/week

○ Next scheduled appointment with this patient: _____

6. In your opinion, is the illness or injury arising out of and in the course of employment? ☐ no ☐ yes
7. If yes, have you filed a C4/C48 with our carrier EM Risk Management at PO Box 325 Syracuse, NY 13206? ☐ no ☐ yes
8. Physician's name (please print): _____
   Office address: _____
9. Physician's Signature: _____ Date: _____

Claim for Benefits

Sheriff/Corr

Instructions: Both sides of this claim form are to be completed whenever a Tompkins County Sheriff's Department employee requests payment for absence due to illness or injury. Disability for personal illness or injury will be granted from the date the employee sees a physician, is deemed unable to work, and a completed claim form is submitted to Personnel by Monday following the end of the pay period in which disability is requested. A faxed copy will be accepted in an emergency, however, the original claim form must be received within five working days. Untimely receipt of a claim form will void a claim for benefits. **Claim forms must be submitted for every pay period that disability is claimed.** In no instance will disability be granted for periods prior to a doctor's visit.

To be completed by Employee Only

1. Name: _____ _____
   first last
2. Date of birth: ____/____/____ Social Security Number: _____-_____-_____
3. Address: _____
   City: _____ State: _____ Zip Code: _____
4. Telephone Number: _____
5. Job Title: _____ Department: _____

6. Date of Injury/Illness: _____/_____/_____
   Date you became unable to work:
   _____/_____/_____
7. Date you saw a doctor regarding this claim: _____/_____/_____
8. Current work schedule: shift: _____
   hours per week: _____
   regular days off: _____

Nature of Illness/Injury (how, where and when did it occur):
_____
_____
_____
_____
_____
_____

9. What benefits are you claiming? (check all that apply):
   - ☐ Wages, salary or disability
   - ☐ Damages for personal injury
   - ☐ Workers' compensation benefits
   - ☐ Unemployment Insurance Benefits
   - ☐ No fault automobile insurance benefits

10. Since your injury/illness have you worked for any other employer or have you been self employed?
    ☐ yes ☐ no
    If yes, please indicate date:
    _____/_____/_____
    Name of Employer: _____
    _____

11. I hereby claim benefits and certify that for the period covered by this claim I was disabled, and that the foregoing statements, including any accompanying statements, are true and complete. Further, I authorize my medical provider to disclose any medical documentation associated with this claim for disability benefits.

Signature: _____ Date: ____/____/____