THE UNIVERSITY OF CHICAGO

Effective 04/2010

Questions about this form? Contact HRS Benefits
E-mail: Benefits@uchicago.edu

POSTDOCTURAL SCHOLARS (PDS)
REQUEST FOR SHORT-TERM DISABILITY LEAVE

PLEASE PRINT

Name: ____ Date of Birth: ___________________

Home/Mailing Address: ____

City, State Zip: ____ Home Phone: __________________________

Job Title/Position: ___________________Department: ____

Faculty Mentor: ____ Date Last Worked: ________________

Reason for Leave: Describe the nature of your non-work related illness, injuries or disability, including pregnancy:

____

Name of Hospital, if confined: ____

Date Admitted ________ Date Discharged: _________ Primary Physician: _____________________________

Date Leave to Begin: ______________________________ Date Leave to End: ___________________________

CONDITIONS:
In claiming disability benefits, I understand that I must be unable to work for a continuous period exceeding 14 calendar days; that my disability is NOT due to any accident or illness connected with my work; and, that I am seeking benefits within 2 weeks of my first day of absence, if not prior to my last day worked. I understand that my attending/primary physician must complete and submit the attached **Physician's Statement** as part of my claim for benefits. I understand that I may be asked to present a P**hysician's Release to Duty** before returning to work. Further I must contact the Absence Management Coordinator at least 2 weeks in advance, if an extension to my leave is necessary and that it must be accompanied by a physician's statement of need.

I understand that the benefit payment will be 60% of base salary, and that it may continue so long as I am disabled or until the end of the 13th week period beginning with my first day of absence or my appointment, whichever is shorter. I understand that I may maintain all benefits for which I am enrolled and make payment arrangements for associated premiums. I understand that all disability periods under this claim will be designated medical leave under FMLA and that these periods will be counted against the allowable 12 weeks under FMLA provisions.

Signature: ____ Date: ___________________________

Associate Dean: Complete the following and return form to the address or fax number below:

Appointment Begin Date: _______________ Base Salary: __________Last Day Worked: _________________

Paid Sick Leave (as of first day of absence): _____hrs Paid Sick Leave will be used from: ________to_____

Associate Dean: ____
Please Print Name

Date: _________________ Signature: ____

Return to: **Absence Management Coordinator** **Fax: 773-702-6098**
HRS – 6054 S Drexel Avenue, Chicago, IL 60637

---OFFICE USE ONLY---

_________ Approved: Benefits effective date: ___________ Denied: __________ Type: _____________

HRS Name, Signature: ____

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SHORT-TERM DISABILITY – ATTENDING PHYSICIAN'S STATEMENT

Physicians: Please print and complete with attention to detail. NOTE: "unknown, undetermined" are not acceptable as answers. Specific dates must be provided where indicated.

Employee Name: ____

Diagnosis and Concurrent condition(s): ____

____ ICD- 9 Diagnostic Code(s): _____________________

Has employee/patient been tested or treated for said conditions previously? If so, please indicate all dates:
____

Date first examined for said condition(s): ___________ Is the condition related to an accident? ___________

Describe primary symptoms and significant objective findings: _____________________________________

____

Hospitalized? State Admission/Discharge dates and attach admission and discharge summaries: __________

Did patient have or will surgery be scheduled: ____________ If so, indicates date(s) and state type of surgery:

____

Specific dates when seen for current condition(s): ____

Next Treatment/Examination Dates: ____

Is employee totally unable to work as a result of this condition? _____________________________________

As of what date do you consider the employee disabled from performing any job functions? _________________

Expected date employee may return to:

Restricted Duty: _____________ **For what period of time (# of days):** ____________

State Restrictions: ____

____

Regular Duty: ______________ **Is this Estimated or Actual:** ____________________

Physician Name and Degree: ____

Address: ____ Phone: __________________

City, State, Zip: ______________________________________ Fax: ____________________

Signature: ____ Date: ___________________

NOTICE: An employee must be physically unable to perform all duties of his/her job and be under the care of a physician during the time period specified in this claim for disability benefits. Any falsification of or failure to produce requested information and supporting documentation may result in delay or denial of benefits and if warranted, disciplinary action up to and including discharge.