**CENTENARY COLLEGE OF LOUISIANA**
**SHORT TERM TEMPORARY DISABILITY INSTRUCTIONS**

***STEP 1: APPLYING FOR SHORT TERM DISABILITY BENEFITS***

**1.** Complete the Application for Short Term Disability Benefits Form, 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 physician complete the remainder of the Medical Certificate and sign.

**3.** You or your doctor may fax the completed form(s) to the Department of Human Resources at 318.841.7366. They may also be mailed to: Department of Human Resources, 2911 Centenary Boulevard, Shreveport, LA 71104.

**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 representative.

***Failure to provide medical information within 3 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 and report your injury immediately to the Department of Human Resources at 318.869.5191 or 318.869.5195.

***STEP 2: SUBMITTING UPDATED MEDICAL CERTIFICATES WHILE OUT ON TEMPORARY DISABILITY***

**1.** Once your disability is approved, you will receive written notification, along with additional Follow- up Medical Certificates to be used for updates if necessary.

**2.** It is ***your*** responsibility to make sure your doctor completes updated medical certificates promptly and submits them to the Department of Human Resources as requested. 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 your physician prior to returning to work. Please advise the Department of Human Resources and your supervisor of any work restrictions by your treating physicians upon your return.

**2.** Notify your supervisor of your anticipated return to work.

For more information on the Short Term Disability Policy, please call Human Resources at 318.869.5191 or visit http://www.centenary.edu/attachments/hr/benefits/shorttermdisabilityappmay2015.pdf.

**CENTENARY COLLEGE OF LOUISIANA**
**APPLICATION FOR SHORT TERM DISABILITY BENEFITS**
(Application must be accompanied with first medical certificate)

To be considered for short term disability benefits, this application ***and*** the medical certificate must be returned to:
**Department of Human Resources, 2911 Centenary Boulevard, Shreveport, Louisiana 71104**

NAME SSN

ADDRESS CITY STATE ZIP

CONTACT NUMBERS/ALTERNATE CONTACT NUMBER 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: _____

_____

Provide 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, provide the date of the first day on which you were able to resume work? _____

Is your condition related to your occupation? _____Yes _____No If yes, explain. _____

Have you filed, or do you intend to file a Workers' Compensation claim? _____Yes _____No

Provide the date of injury. _____

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

PHYSICIAN ADDRESS OF PHYSICIAN PHONE NUMBER

DATE YOU WERE FIRST TREATED BY THIS PHYSICIAN FOR THIS CONDITION

## OTHER EMPLOYER 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 Centenary College 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 CONTACT NUMBER DATES OF EMPLOYMENT WITH OTHER EMPLOYER

**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 hereby give my permission for release of any medical information required by Centenary College for the processing of my temporary disability benefits.

SIGNATURE DATE

*CONFIDENTIAL – MEDICAL CERTIFICATE (must accompany application form for short term disability benefits)*
**CENTENARY COLLEGE OF LOUISIANA,**
**DEPARTMENT OF HUMAN RESOURCES**

***Return completed medical certificate to the Department of Human Resources via fax at 318.841.7366 or email at hr@centenary.edu or physical mail to*** Department of Human Resources, 2911 Centenary Boulevard, Shreveport, Louisiana 71104

*TO BE COMPLETED BY THE EMPLOYEE:*

NAME _____ SSN _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CONTACT NUMBERS/ALTERNATE CONTACT NUMBER _____ DEPT/SUPERVISOR _____

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

SIGNATURE _____ DATE _____

*TO BE COMPLETED BY THE PHYSICIAN:*

1. DIAGNOSIS AND CONCURRENT CONDITION

2. IS CONDITION THE RESULT OF A WORK RELATED SICKNESS OR INJURY? _____YES _____NO

PREGNANCY? ____YES _____NO IF YES, APPROXIMATE PREGNANCY DUE DATE:_____

3. DATES OF SERVICE (LIST ONLY DATES NOT PREVIOUSLY REPORTED ON HEALTH CLAIM FORM)

4. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED.

5. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION.

6. HAS PATIENT EVER SUFFERED FROM SAME OR SIMILAR CONDITION:

_____YES _____NO IF YES, WHEN AND DESCRIBE:

7. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?

_____YES _____NO

8. PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK).

FROM: _____ THRU: _____

9. PATIENT WAS PARTIALLY DISABLED.

FROM: _____ THRU: _____

10. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK:_____

11. DATE ABLE TO RETURN TO WORK WITH RESTRICTIONS:_____

12. 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 Centenary College of Louisiana for the processing of the above employee's temporary disability benefits.

PHYSICIAN NAME _____ ADDRESS OF PHYSICIAN _____ PHONE NUMBER _____

PHYSICIAN'S SIGNATURE (REQUIRED) _____