Short-Term Disability/FMLA/Supplemental Leave Application Medical Certification

To Be Completed by Physician (Please Type or Print)

Chicago Public Schools (CPS) • Talent Office Absence & Disability Department
2651 W. Washington Blvd, Chicago, IL 60612
Telephone: 773-553-HR4U(4748) • Facsimile: 773-553-FMLA(3652) • Email: cpsloa@cps.edu

Patient's Name:_____ **Employee ID:** _____

SECTION 1: REQUIRED INFORMATION TO SUPPORT FMLA LEAVE

1. Approximate Date condition commenced:_____/_____/____Probable duration: _____
2. Will the patient be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? Yes ☐ No ☐
   If yes, provide the beginning and ending dates for the period of incapacity:_____/_____/____-_____/_____/____
3. Has the patient recovered sufficiently to return to work? Yes ☐ No ☐
   If "Yes", give the date the patient was able to return to work_____/_____/____
   If "No", in your opinion when may work be resumed? (Please do not use "indefinite", "unknown", "undetermined", etc.) If a date cannot be determined, please estimate in days, weeks or months. _____/_____/_____
   _____
4. Date(s) you treated the patient for condition: _____
5. Describe other relevant medical facts related to the condition for which the employee seeks leave including symptoms, diagnosis or any regimen of continuing treatment:
   _____
   _____
6. Was medication other than over-the-counter medication prescribed? Yes ☐ No ☐
7. Is the medical condition pregnancy? Yes ☐ No ☐ If yes, expected delivery date: _____
8. Is the patient unable to perform any of his/her job functions due to their condition: Yes ☐ No ☐
   If yes, identify the job functions the employee is unable to perform (use the list of the employee's essential functions or job description attached to this form)
   _____
   _____
   _____

SECTION 2: REQUIRED INFORMATION TO SUPPORT SHORT TERM DISABILITY BENEFITS: PERSONAL ILLNESS/PREGNANCY IF THE REASON FOR THIS LEAVE REQUEST IS DUE TO BEHAVIORAL HEALTH OR AN ADDICTION COMPLETE SECTION 3

1. Objective findings: HT: WT: BP: TEMP: PULSE: RESP: _____

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2. Patient's Complaints: _____

_____

3. Your Diagnosis: (list all disabling diagnoses including all ICD9/10 codes)

Primary: ICD9/10 Code: _____ Secondary: ICD9/10 Code: _____ ICD9/10 Code: _Description:____

Description:_____ Description:_____

4. Describe objective/clinical findings to warrant disability, including severity and duration based on the patient's presentation during office visits. _____

_____

_____

5. When was patient first diagnosed with this condition?_____/_____/_____

6. When is the patient's next office visit?_____/_____/_____

7. Have there been any Emergency Room visits OR Hospitalizations during this current disability period? Yes ☐ No ☐

If Yes: ☐ Emergency Room visit ☐ Hospitalization ☐ 23 hour admission

Name and address of hospital or facility: _____

_____

8. List all medications, identify dates of new medications or dose adjustments: (attach list if necessary)

Medication	Dose	Frequency	Duration	New Med	Adjusted Med	Date Adjusted
_____				Yes ☐ No ☐	Yes ☐ No ☐	___/____/____
_____				Yes ☐ No ☐	Yes ☐ No ☐	___/____/____
_____				Yes ☐ No ☐	Yes ☐ No ☐	___/____/____
_____				Yes ☐ No ☐	Yes ☐ No ☐	___/____/____

If patient is pregnant, is a C-Section planned? Yes ☐ No ☐ If yes, date scheduled? _____/_____/_____

9. What is the prescribed treatment plan? (please provide specific details regarding treatment/therapy, attach notes if necessary):_____

_____

_____

10. Has any surgical procedure related to current disability been performed or is any anticipated? Yes ☐ No ☐

List the name of the procedure: _____

CPT code:_____ Date of procedure:_____/_____/_____

11. Has patient been referred to any other physician(s)/specialist? Yes ☐ No ☐ If yes, provide physician name, specialty, and telephone number. _____

_____

12. List specific functional limitations of Activities of Daily Living (ADL's): _____

_____

13. Has the patient recovered sufficiently to return to work with restrictions? Yes ☐ No ☐

If "Yes", indicate date restrictions begin:_____/_____/_____ Date restrictions end:_____/_____/_____

Restriction (s) required: _____

_____

_____

SECTION 3: REQUIRED INFORMATION TO SUPPORT DISABILITY BENEFITS BEHAVIORAL HEALTH

The patient's disability plan requires that medical information indicate an inability to perform the essential duties of his/her own job. Patient's occupation:

_____

Have you recommended to your patient to stay home from work? ☐ Yes ☐No If yes, effective what date? _____

Please provide your rationale for recommending disability leave _____

COGNITIVE FUNCTIONING

Memory functions: No Impairment ☐ Mild Impairment ☐ Moderate Impairment ☐ Severe Impairment ☐

Applied focus and concentration in session for periods of:
☐30 to 50 minutes ☐ 15 to 30 minutes ☐ 5 to 10 minutes ☐ less than 5 minutes

Expressed his/her current circumstances and responded to direct questions appropriately: ☐ Yes ☐ No
If No, was direction needed? Please describe: _____

Reasoning and/or Judgment: ☐ Within normal limits ☐ Impaired
If impaired, describe: _____
Delusional ideations evident: ☐ Yes ☐ No Describe: _____
Hallucinations reported: ☐ Yes ☐ No Describe: _____

EMOTIONAL FUNCTIONING

Emotional state during exam (Describe affect type, range, intensity, and congruence with content discussed):_____

_____

Able to spontaneously compose her/himself: ☐ Yes ☐ No Explain: _____
Panic attacks: ☐ Yes ☐ No Please specify below:

- Symptoms experienced: _____
- Frequency of panic attacks: _____
- Duration of panic attacks: _____

BEHAVIORAL OBSERVATIONS

Date of last exam: _____

Behaviors observed during exam: _____

Psychomotor activity and ability to apply effort: ☐ unremarkable ☐ Impaired If impaired, describe: _____

Presented with appropriate dress and hygiene in session: ☐ Yes ☐ No Describe: _____

Impulse control (e.g. substance abuse, manic behavior, aggressive behavior): _____

Speech: ☐ Slurred ☐ Pressured ☐ Stammering ☐ Loud ☐ Soft ☐ Over Productive ☐ Under Productive ☐Other: _____

	SUICIDAL IDEATIONS	HOMICIDAL IDEATIONS
Risk to self/others:	☐ Yes ☐ No	☐ Yes ☐ No

Plan reported: ☐ Yes ☐ No If yes, please describe: _____

Able to report reasons for not harming self/others: ☐ Yes ☐ No If no, please explain: _____

Contracted for safety: ☐ Yes ☐ No If no, please explain: _____

PATIENT SELF REPORT OF ACTIVITIES OF DAILY LIVING

Is the patient currently performing any of the following? ☐Volunteer work ☐ Work at a less demanding job ☐Attend school ☐ No work activities in any capacity ☐ Self-employment

Significant weight/appetite changes: ☐ Yes ☐ No If yes, describe: _____

Sleep disturbance: ☐ Yes ☐ No If yes, describe: _____

Socialization problems: ☐ Yes ☐ No If yes, describe: _____

Operates motor vehicle: ☐ Yes ☐ No If no, explain: _____

Cleans/Maintains residence: ☐Yes ☐No Performs routine shopping: ☐ Yes ☐ No Pays bills: ☐ Yes ☐No

Operates motor vehicle: ☐ Yes ☐ No If no, explain: _____

TREATMENT

Date initiated care: _____

Inpatient Care: Date(s) of hospitalization: _____

Partial hospitalization program: Date(s) of care: _____

Intensive outpatient (IOP): Start date: _____ End Date: _____

Days per week: _____ Hours per day: _____

Outpatient psychotherapy: Frequency: _____ Date of next visit: _____

Medication Management: Frequency: _____ Date of next visit: _____

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Current medications/changes in medication, list all medications, identify dates of new medications or dose adjustments: (attach list if necessary)

Medication	Dose	Frequency	Duration	New Med	Adjusted Med	Date Prescribed/Changed
					☐ Yes ☐ No	☐Yes ☐ No
					☐ Yes ☐ No	☐Yes ☐ No
					☐ Yes ☐ No	☐Yes ☐ No

Medication side effects: ☐ Yes ☐ No If yes, describe: _____

DIAGNOSTIC IMPRESSIONS

Axis I:_____Axis II:_____Axis III:_____ Axis IV: _____

Axis V: _____ GAF Current: _____ GAF Prior to Leave: _____

Patient's perspective: The Patient has conceptualized the following areas as barriers in returning to work:

☐Increase in work demands ☐ Conflicts with supervisor ☐ Anticipation of relapse

☐Recent unfavorable work evaluation ☐ Dissatisfaction with the job ☐ Other

SECTION 4: RETURN TO WORK

Currently, my patient is:

☐Released to work full duty on: _____

☐Able to work with accommodations: _____

☐Unable to work at this time; Projected return-to-work date: _____

"The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."

Please attach all office notes, History & Physical, results of x-rays, laboratory tests, MRI Reports, etc, if relevant.

Telephone Number: _____ Physician Printed Name: _____

Fax Number: _____ Physician Specialty: _____

Date Completed: _____ Physician Signature: _____

Short-Term Disability Supplemental Form

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Acknowledgement of Start/Stop Benefits

I, _____, acknowledge that Short-term disability benefits are only provided during regular scheduled work time. My STD benefits and income loss payments are not paid during any scheduled unpaid periods such as fall, winter, spring, intersessions and summer break. Holiday pay during an STD period will be paid by CPS and the day will count towards the 90 day max.

In the event my approved disability period overlaps into one of the above-mentioned unpaid periods, excluding summer, my disability benefits will stop, and disability payments will not be made, however, those days will count towards my 90 day max. Only during the periods of paid holidays, fall, winter, and spring intersessions will an automatic continuance of STD benefits restart at my next regular scheduled work day if your approved STD period goes beyond the intersession.

As a school-based employee, if my disability overlaps into the summer break period then my existing STD benefit will end on the last effective date of my regular scheduled work day. If I am still disabled at the beginning of the school year, I must apply to extend the STD benefit and submit updated medical information. If my disability does not exceed the 90 day maximum in the rolling 12 month period, then my disability will continue at the weekly base pay from the previous benefit period.

Acknowledgement of Sick Day Bank Usage

As part of my STD benefits, I, _____, authorize Chicago Public Schools to supplement the STD payment in days 31 through 90 to reach 100% income during such period by usage of my sick day banks. I acknowledge that usage of these days must be in accordance with Chicago Public Schools' sick day policy.

Please sign below for the usage of benefit time during days 31 – 90.

I acknowledge that this form must be signed and authorized in order for Chicago Public Schools to supplement sick days for income loss during STD. Benefit days will be will be paid out based on the Exhaustion Hierarchy in the Paid Time Off Policy, 302.9.

Important note: There will be no retroactive sick day usage if you fail to return this form.

_____ _____

Signature Date

Short-Term Disability Overpayment Form

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In consideration of payment to me of benefits under any sponsored Short Term Disability Plan, I hereby agree to reimburse Chicago Public Schools (CPS) to the extent any such benefits were paid to me under the Short Term Disability Plan erroneously, or which should be offset in accordance with the Short Term Disability Plan, by reason of my eligibility for benefits (1) under any federal Social Security law, (2) under any workers' compensation law, whether by formal award, redemption award, informal compromise, or otherwise, or (3) from any other sources that CPS, the Short Term Disability Plan claim administrator, deem are to be taken into account in determining the amount of Short Term Disability Plan benefits. As a means to obtain reimbursement, I hereby give CPS my full and free consent to offset against any benefits for which I am eligible under the Short Term Disability Plan or any compensation (excluding wages payments) or other employee benefits payable to me by CPS until reimbursement is complete. I understand this agreement remains in effect until any overpayment owed the Short Term Disability Plan has been paid in full.

I understand that if any monies or benefits listed in items 1, 2, and 3 above are awarded retroactively, they shall be treated as having been received during the entire time period for which Short Term Disability Plan benefits were payable and any overpayment of benefits shall be calculated accordingly. I understand that that this Reimbursement Agreement must be signed by me to receive CPS Short Term Disability Plan benefits.

Name _____ Date _____