COUNTY OF INYO
SHORT-TERM DISABILITY INSURANCE PROGRAM

Employee Application for Benefits

Employee's Name: _____ Home/Cell Phone #_____

Mailing Address: _____

Email Address: _____

Position Title: _____ Employing Department: _____

Date of Birth: _____What was the last date worked? _____

What was the first day you were too sick or injured to perform the normal duties of your job (even if it was a weekend, holiday, or normal day off)?_____

What is your weekly work schedule? (M-F, T-F, etc.)_____ Daily Shift Hours (8, 9, 10, 12, BPAR, etc.)_____

Please state the name(s) and address(es) of all physicians that are treating you for this condition:

_____

_____

Have you recovered from this disability? Yes □ No □ If so, give a date of recovery: _____

Was this disability caused by your work? Yes □ No □

If so, have you filed a Worker's Compensation claim? Yes □ No □

Do you have any other disability insurance policy? Yes □ No □. If so, state policy number, company name, and address:

_____

I hereby apply for benefits under Inyo County's Short Term Disability Program. I declare, under penalty of perjury, that the foregoing statements are true, complete, and correct, to the best of my knowledge. I authorize my attending physician, medical practitioner, hospital, or other medical provider to furnish and disclose all facts, records, and reports concerning my disability, and release such providers from any liability resulting from the use of this information. This authorization is valid for a period of 18 months from the date of my signature or the effective date of the claim, whichever is later. I agree that photocopy of this release shall be as valid as the original.

Employee's Signature_____ Date_____

Employee: Have your physician complete the "Physician's Certificate of Disability" on the reverse side of this form and return it to:

Inyo County Personnel Department
P.O. Box 249
Independence, CA 93526

IMPORTANT: The claim must be mailed within 49 days of the date you became disabled if you are to receive credit from the date you first became disabled. If the claim is mailed late and you believe that you have "good cause", you should include an explanation on a separate sheet attached to the claim form.

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PHYSICIAN'S CERTIFICATION OF DISABILITY

Certification of disability must be made by a licensed medical or osteopathic physician and surgeon. All items on this sheet must be completed legibly.

Patient's Name_____

Patient's Date of Birth: _____

I attended the patient for the present medical problem from _____ (month, day, year) to _____(month, day, year).

Has the patient been incapable of performing his or her regular work at any time during your attendance for this medical problem? Yes □ No □. If yes, state date disability began_____(month, day, year).

When do you anticipate that the patient will be sufficiently recovered to return to work? _____ (month, day, year). (This is an estimate only; "indefinite" or "don't know" will not suffice.)

Based upon your examination of the patient, is this disability work related? Yes □ No □. If yes, please explain:

_____

I hereby certify, under penalty of perjury, that the above statements truly and correctly describe the patient's disability, if any, and the estimated duration thereof.

Physician's Signature_____ State License Number _____

Physician's Name and Degree (please print)_____
Address_____

Telephone Number: (_____)_____ Date Form Signed_____

RETURN TO: **INYO COUNTY PERSONNEL DEPARTMENT**
P.O. Box 249
Independence, CA 93526
Phone: (760) 878-0377 **Fax: (760) 878-0465**

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