To be completed by Physician Only

Claim for Benefits

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

Tompkins County Personnel Department (607)274-5526 (phone)
125 East Court Street
Ithaca, NY 14850 **(607)274-5401 (fax)**

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? Yes ☐ No ☐ 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/wk

6. **In your opinion, is the illness or injury arising out of and in the course of employment?** Yes ☐ No ☐ **If yes, have you filed a C4/C48 with our carrier EM Management at 111 Grant Ave. Endicott, New York 13760?** Yes ☐ No ☐

7. **Physician's name (please print):** _____
8. **Office address:** _____
9. **Physician's Signature:** _____ **Date:** _____/____/____

Confidential/Used by Personnel Department Only

To be completed by Employee Only

Claim for Benefits

Instructions: Both sides of this claim form must be completed whenever a Tompkins County 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 9:00 AM, 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 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.

What is your affiliation (White Collar, Blue Collar, Corrections, Road/Civil or Management/Confidential): _____

1. Name: _____ _____
   first last
2. Date of birth: ____/____/____ Social Security Number: _____-_____-_____
3. Street address: _____
   City: _____ State: _____ Zip: _____
4. Phone number ( ) _____-_____
5. Job Title: _____ Department: _____

6. Date of Injury/Illness: _____/_____/_____ Nature of Illness/Injury (how, where and when did it occur): _____
   Date you became unable to work: _____/_____/_____
7. Date you saw a doctor regarding this claim: _____/_____/_____
8. Current Work Schedule:
   Shift/Hours: _____
   Regular Day(s) Off: _____

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?
    ☐ Yes ☐ No
    If yes, please indicate date:
    _____/_____/_____

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.

    Signature: _____ Date:_____/_____/_____

Confidential/Used by Personnel Department Only