Syracuse University
Human Resources

APPLICATION FOR DISABILITY/MATERNITY BENEFITS

Return to: HR Service Center
621 Skytop Road, Suite 1001
Syracuse, NY 13244-1200
leaveadmin@syr.edu
Phone: 315.443.4042
Fax: 315.443.1063

Pages one and two of this form should be completed by the employee.

Pages three and four must be completed by the employee's physician.

EMPLOYEE INFORMATION (please print or type)

Full name (Last, First)	SUID	
Address		Phone#
Date of Birth	Male ☐	Female ☐
List the duties of your occupation at the time of disability:		
I have been unable to work because of this disability since: (Month/Day/Year)	I returned to work on a part- time basis: (Month/Day/Year)	I returned to work on a full- time basis: (Month/Day/Year)
Date of your accident or date you first noticed the symptoms of your injury/illness: (Month/Day/Year)	Is your injury/illness related to your occupation? Yes ☐ No ☐	If yes, explain:
Describe how and where accident occurred or describe the first symptoms of your injury/illness:		
Date you were first treated for your illness or injury: (Month/Day/Year)	Treated by Physician - Name and Address: Hospital Name and Address	

Have you ever had the same or similar condition in the past? Yes ☐ No ☐	Treated by Physician - Name and Address: Hospital Name and Address:

Describe any other income you are receiving or are eligible to receive as a result of your disability:

Source of Income	Amount of Income	Date Income Began	Date Income Ended

The above statements are true and complete to the best of my knowledge and belief. Except to the extent prohibited by an applicable state or local law, I hereby authorize any hospital or physician who has treated me, or person who has attended me or examined me, in connection with the condition(s) set forth in this application, or any company or government agency with records relevant to my claim, to furnish to Syracuse any and all information with respect to any illness medical history, consultations, prescriptions, treatments or benefits, relevant to the condition(s) set forth in this application, and copies of all applicable records. A copy of this form will be as valid as the original.

_____ _____

Employee Signature Date

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ATTENDING PHYSICIAN'S STATEMENT - ACCIDENT/ILLNESS/MATERNITY

1. Patient's Name	Age	Date symptoms first appeared or the accident happened:

2. Nature of Injury or Illness - Diagnosis (describe complications if any)

3. Is condition due to injury or illness arising out of patient's employment? If "Yes", explain. Yes ☐ No ☐

4. Date patient first consult you for this condition?

5. Has patient ever had same or similar condition? If "Yes", state when and describe. Yes ☐ No ☐

6. Describe any other injury/illness affecting present condition.

7. Nature of surgical or obstetrical procedure, if any. (describe fully)	Date:

8. Dates of treatment:
Office _____ Home _____ Hospital _____

9. If patient hospitalized, name and address of hospital:	Date Admitted:
Name _____	_____
Address _____	Date Discharged:
_____	_____

10. How long was or will patient be continuously totally disabled (unable to work)?

From: _____, Yr._____ Through _____, Yr._____

11. How long was or will patient be partially disabled?

From: _____, Yr._____ Through _____, Yr._____

12. Is the patient competent to endorse checks and direct the proceeds with a clear understanding of the nature of his acts?

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entitiescovered by GINA Title II from requesting or requiring genetic information of an individual except 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 reproductiveservices.

PHYSICIAN'S COMMENTS

Physician's Name (please print) Degree

Street Address

City or Town State Zip Code

Phone

Physician's Signature Date