ASPIRUS
Passion for excellence. Compassion for people.

LEAVE MANAGEMENT SERVICES

ATTENDING PROVIDER STATEMENT
SHORT TERM DISABILITY REQUEST

Leave Management Services, 135 S. Gibson St., Medford, WI 54451
E-mail: leavemanagementservices@aspirus.org Phone: 715-748-8115 Fax: 715-748-8832

EMPLOYEE SECTION

1. Employee Name	2.DOB	3. Job Title / FTE
4. Employee Address City State Zip		5. Phone # ( )
6. Briefly explain reason for leave request:		
7. Leave Start Date:	8. Leave End Date:	
9. Is your leave related to a work related injury or illness? □ Yes □ No		
10. If you are eligible for Short Term Disability benefits, during your waiting period, do you wish to use PTO? □ Yes □ No *Please refer to your employer's PTO policy regarding usage of PTO during a designated leave.		
11. If you are approved for Short Term Disability benefits, do you wish to use PTO to supplement your pay to 100% each week? □ Yes □ No		

12. By my signature below, I demonstrate my informed consent and authorization to allow my healthcare provider named in **Health Care Provider Section**, to release, disclose and communicate to my employer or employer representative such health care records and information concerning my current medical condition(s) as is necessary to support my request for a leave of absence and/or any additional benefits my employer may provide. I further authorize my employer or employer representative to contact my healthcare provider directly for the purposes of clarification and verification of the authenticity of this certification. The authorization shall be valid for one (1) year from the date shown below, unless revoked by me in writing at an earlier date. Although I understand that I may revoke this authorization in writing at any time, I also understand that any such revocation will not apply to any information that has already been released in reliance on this authorization, and that any revocation may have an adverse effect on the receipt of Employer-provided benefits. I understand that information disclosed by my healthcare provider to my employer or employer representative may be subject to redisclosure and not protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The information shall not be released to my immediate supervisor.

I authorize my healthcare provider to complete and provide these certification forms directly to my employer via fax or mail.

Employee Signature _____ 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.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT : If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210.

HEALTH CARE PROVIDER SECTION

Completion of this entire form by the attending Health Care Provider based on a recent examination. Attach additional documentation as needed. Your patient is responsible for the cost of completing this form.

1. For medical reasons, the patient will need to be absent from work due to a disability beginning on _____/_____/_____ and ending _____/_____/_____.

2. Primary Diagnosis: Secondary Diagnosis:	Primary ICD Code: Secondary ICD Code:

3. Medical evidence that substantiates or contributes to this patient's inability to work (please attach results of x-rays, MRIs, EKGs):

4. Subjective complaints:

CONDITION HISTORY

5. Patient's symptoms are the result of (check all that apply):
□ Employment □ Illness □ Pregnancy □ Other: _____

6. Date symptoms first appeared or accident occurred: _____/_____/_____	7. Date of your first evaluation for this condition: _____/_____/_____
8. Frequency of visit/treatment for this condition: □ Weekly □Monthly □ Other _____	9. Date of next visit/treatment for this condition: _____/_____/_____

10. If inability to work is due to pregnancy, please indicate: □ expected □actual (check one) deliver date: _____/_____/_____
Delivery type: □Vaginal □Cesarean

11. Was patient recently hospitalized? □ No □ Yes Date hospitalized: Admit _____/_____/_____ Discharge _____/_____/____
Hospital Name/City:

12. If surgery, date: _____/_____/_____ Outpatient: □ Yes □ No
Procedure:

13. Is patient still under your care for this condition? □ Yes □ No, date service terminated _____/_____/_____

14. Did you refer this patient to another physician/or provider for treatment of this or a related condition? □ Yes □ No
If "Yes", please supply the physician's/provider's complete name and address and phone number:

TREATMENT

15. Describe the patient's treatment program/medications/dose/frequency

PROGRESS

16. If the patient been released to return to work, please complete the attached Return to Work Form.

Remarks:

*As defined in the Federal Dictionary of Occupational Titles

HEALTH CARE PROVIDER INFORMATION

17. Provider's Name	18. Credential	19. Specialty
20. Address City State Zip		21. Phone # ( )
22. Fax # ( )	23. E-mail	
Signature		Date