Newtown Police Department
Three Main Street
Newtown, CT 06470

David Kullgren
Chief of Police
Tel. (203) 426-5841
Fax (203) 270-0637

TOWN OF NEWTOWN

APPENDIX B
Short Term/Long Term Disability
Non-Work Related Injury Procedures & Documentation

The following flow chart identifies the short term disability request (STD) process and documentation, and is further detailed in department policy and procedure 1.23 Employee Injuries.

Preplanned Procedure/Treatment/Injury	Emergency or Urgent Procedure/Injury/Illness
Employee notifies Admin LT of a preplanned procedure or treatment requiring more than 5 consecutive sick days.	Employee notifies on duty Shift Commander of emergency procedure/treatment requiring more than 5 consecutive sick days.
It is the employee's responsibility to obtain the Short Term disability package (available in PIN and Town Website). - All forms must be received at least 5 working days prior to the employees' leave for such procedure/treatment. - Admin Lt will notify HR per P&P. - Once STD is approved, scheduled sick leave will be modified according to CBA & P&P.	It is the employee's responsibility to obtain the Short Term disability package (available in PIN and Town Website). - All forms must be received within 5 working days after such treatment. - Shift Commander will notify HR and Admin Lt per P&P. - Once STD is approved, scheduled sick leave will be modified according to CBA & P&P.

Short Term Disability Package

1. Town Medical Certificate
- Completed by attending physician and returned to Admin Lt. Admin Lt will advise HR.

2. Town Short Term Disability Request Form
- Completed by employee and the Admin Lt.
- Admin Lt then submits to First Selectman for approval.

3. TR Paul form
- (Employee completes Section A, Admin Lt completes Section C, attending physician completes Section D) Only submitted on initial report.
- Attending physician or employee submits completed form directly to TR Paul (email Wendy Mauro wmauro@trpaul.com, or fax her at 203-270-0927.

Notes
- All documents submitted to the department will be filed in the employee's medical file (Town STD Request form & Town Medical Certificate).
- It shall be the sole responsibility of the employee to ensure all forms are submitted to the proper persons on time.
- Failure to submit any of the forms on time may result in delay and/or denial of STD benefits.

TOWN OF NEWTOWN

MEDICAL CERTIFICATE

The employee shall give this form to his/her physician or medical practitioner. The form will be returned to the following address:

Office of the Chief of Police
Newtown Department of Police Services
191 South Main Street
Newtown, Connecticut 06470 **FAX # 203-270-3779**

The attending physician or medical practitioner is requested to complete the form in order that the Newtown Department of Police Services will be better able to administer the duty status of the following named employee:

Name of Patient: _____ Physician's Name:_____

Date of Examination: _____ Physician's Address:_____

Injury or Illness (optional) _____

Please check off and provide information that pertains to this patient. This information provided should be time period specific allowing the agency to determine the employee's work status on a day-to-day basis or for a specific time period:

_____ The Patient, after an examination on: _____, is physically **able** to return to Full Duty as a police officer or civilian employee (if you require a list of duties and responsibilities to make this determination please contact the Office of the Chief of Police). **Date of return to full duty status**:_____

_____ The Patient, after an examination on: _____, is physically **unable** to perform (1) the full time duties of a Newtown Police Officer or (2) the duties of a civilian employee or (3) in a light duty capacity. ** The Town of Newtown reserves the right to send the patient for a second opinion regarding light duty status at the Town's expense.

_____ The Patient, after an examination on: _____, is physically **able** to perform Light-Duty. (Light-Duty work is available at the Newtown Department of Police Services for a variety of restrictions and with modified work hours, subject to availability).

Restrictions related to Light-Duty if any:_____

_____

_____

*The date of the next appointment for the patient to be re-evaluated regarding his work status:_____

OR

*Patient referred to a specialist (yes or no). Date of appointment with specialist: _____

Any additional comments: _____

_____ _____

Physician's Signature Date

*Must be filled in if the employee is not returned to full duty status.

The **Return to Work Program Questionnaire must be filled out and returned with the Medical Certificate. (Rev 3/21)

NEWTOWN MUNICIPAL CENTER
3 PRIMROSE STREET
NEWTOWN, CONNECTICUT 06470
TEL. (203) 270-4201
FAX (203) 270-4205
Email address
Patrice.fahey@newtown-ct.gov

TOWN OF NEWTOWN

Patrice Fahey
Human Resources Administrator

OFFICE OF HUMAN RESOURCES

REQUEST FOR SHORT TERM DISABILITY APPROVAL FORM

This form must be completed by each employee who is absent from work or anticipates an absence from work due to a non-work related illness, disability or pregnancy for more than the requisite number of days either under a collective bargaining agreement or the personnel handbook and seeks payment under the short term disability program. The employee must furnish a physician's note, which shall include the diagnosis, first date of disability, expected duration of the disability, and the expected return to work date. After the first five days of absence and for a maximum duration of 26 weeks benefits, shall be paid, if approved, in the amount of sixty-six and two-thirds (66 2/3%) of normal weekly straight time earnings. It is also required to submit physician's notes on a regular basis covering the disability period. Failure to provide documentation of illness/injury to the Town of Newtown will result in suspension of benefit.

EMPLOYEE NAME_____DATE_____

POSITION_____DEPARTMENT_____

NUMBER OF SICK LEAVE DAYS REMAINING_____
FIRST DATE OF ABSENCE DUE TO NON-WORK RELATED ILLNESS OR DISABILITY _____
EXPECTED DATE OF RETURN TO WORK_____

IF OPTION AVAILABLE DO YOU WISH TO USE ANY AVAILABLE LEAVE TIME TO MAKE UP THE 33 1/3 DIFFERENCE IN YOUR PAY?

_____ NO _____ YES HOW MANY DAYS SICK?_____

HOW MANY DAYS PERSONAL?_____

HOW MANY DAYS VACATION?_____

_____ _____
EMPLOYEE SIGNATURE DATE

_____ _____
SUPERVISOR SIGNATURE DATE

Your request for Short Term Disability has been: APPROVED _____DENIED_____

YOUR SHORT TERM DISABILITY WILL BEGIN ON_____

_____ _____
First Selectman DATE

GROUP DISABILITY FORM
WE ARE YOUR
THIRD PARTY ADMINISTRATOR

TRPaul Inc

CLAIMS DEPARTMENT
14 COMMERCE ROAD
NEWTOWN, CT 06470-5508
PHONE: 800-678-8161 FAX: 203-270-0927
Wendy Mauro wmauro@trpaul.com

SECTION A To be completed by employee

Name and home address of the employee (please print) (Last Name) (Mid. Init.) (First Name)	Employer: Town of Newtown	Social Security No.
Number Street City State Zip Code		Date of Birth: NA Per CBA
		Home Phone#: NA Per CBA

Do you work for another employer? NA Per CBA
If yes, employer name, address and phone# NA Per CBA

If injured, how, where and when did the injury happen: NA Per CBA

Date accident or sickness began			Date of first treatment			Date last worked			Date expected to return to work		
Month	Day	Year	Month	Day	Year	Month	Day	Year	Month	Day	Year

Physician's name and address: Telephone Number:

SECTION B To be completed by employee

NA Per CBA

SECTION C To be completed by employer

At beginning of disability employee was:
☑ Working Full Time ☐ Laid Off Work
☐ Working Part Time ☐ On Leave of Absence

	Month	Day	Year		
Date Last Worked:				**Date Returned to Work:** TBD	
Employee's Effective Date: Unknown				**Wages** $ NA Annual Salary	☐ Per Week ☐ Per Month

I certify that to the best of my knowledge, the above statements are true and correct (relative to Section C).

Date **Signature and Title of Official Representative** Admin Lt

SECTION D To be completed by attending physician

1. **PATIENT'S NAME**

2. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

	YES	NO
3. **Is condition due to injury or sickness arising out of patient's employment?**		
4. **Is patient still under your care for this condition**?		
5. NA Per CBA		

DATE

6. **Date symptoms first appeared or accident happened.**
7. **Date patient first consulted you for this condition**
8. **Patient was continuously totally disabled (unable to work, or unable to perform normal duties, household or otherwise).**

From (mm/dd/yy) **thru** (mm/dd/yy)

9. **If still totally disabled, date patient should be able to return to work.**

REMARKS:

10. **Patient's next scheduled visit:**

11. **Was patient Hospital confined?** ☐ **YES** ☐ **NO**

If yes, please provide name & address of hospital

12. **Is Patient being treated by anyone else? If yes please provide name & address:**

Relevant services rendered – Along with Treatment plan (please be specific)

13

Date of Services	Place of Services	Description of Services rendered	Proc

Remarks:

Physician's Name (print)	**Signature**	**Degree**
Street Address	**State & Zip Code**	
Date	**Telephone**	