Newtown Police Department David Kullgren

191 S. Main Street Chief of Police

Newtown, CT 06470 Tel. (203) 426-5841

Fax (203) 270-0637

**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 5consecutive sick days. | Employee notifies on duty Shift Commander of emergency procedure/treatment requiringmore 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.
 |

james.viadero@newtown-ct.gov


## 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 MUNlCfPALCENTER 3 PRIMROSE STREET

NEWTOWN, CONNECTICUT 06470

TEL (203) 270-4201

FAX (203) 270-4205

Email address

Patrice.fuhey@newtown-ct.gov



**TOWN OF NEWTOWN**

OFFICE OF HUMAN RESOURCES

Patrice Fahey

# Human Resources Administrator

## 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

IFOPTION 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 \_

Dan Rosenthal, First Selectman

DATE

**GROUP DISABILITY FORM WE ARE YOUR**

**THIRD PARTY ADMINISTRATOR**

CLAIMS DEPARTMENT 14 COMMERCE ROAD

NEWTOWN, CT 06470-5508

PHONE: 800-678-8161 FAX: 203-270-0927

|  |
| --- |
| **SECTION A** To be completed by employee |
| Name and home address of the employee (please print) | Employer: | Social Security No. |
| (Last Name) (Mid. Init.) (First Name) | Town of | \_ \_ |
|  |
|  | Newtown | Date of Birth: NA Per CBA |
| Number Street City State Zip Code |  |
| Home Phone#: |
|  | NA Per CBA |

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

 NYAePser CBANo NA Per CBA

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

|  |  |  |  |
| --- | --- | --- | --- |
| **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 |
|  |  |  |  |  |  |  |  |  |  |  |  |
| Diagnosis: |
| Physician’s name and address: Telephone Number: |

**SECTION B** To be completed by employee

**I AUTHORIZE** any physicians and my employer having information available as to diagnosis, treatment or prognosis with respect to my current claim for a physical or mental condition to give TR Paul Inc. any and all such information.

**I UNDERSTAND** the information obtained by use of the Authorization will be used by TR Paul Inc. to review eligibility for disability benefits under the Town of Newtown Short Term Disability Policy.

I KNOW that I may request to receive a copy of this Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original. Signature

I AGREE that this Authorization shall be valid for the duration of the policy.

Date

✔

**SECTION C** To be completed by employer

At beginning of disability employee was:

Working Full Time Working Part Time

Laid Off Work

On Leave of Absence

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date Last Worked:** | **Month** | **Day** | **Year** | **Date Returned to Work:** TBD **Month Day Year** |  |
|  |  |  |  |
|  | **Month** | **Day** | **Year** | **Wages Per Week****$** NA Annual Salary **Per Month** |
| **Employee’s Effective Date:** Unknown |
| **I certify that to the best of my knowledge, the above statements are true and correct.****Date Signature and Title of Official Representative** Admin Lt |

1. **PATIENT’S NAME**

**SECTION D** To be completed by attending physician

D**D**es**ia**cr**g**ib**n**e**o**o**s**th**i**e**s**r **a**re**n**le**d**va**C**nt**o**m**n**e**c**d**u**ic**r**a**r**l **e**fa**n**c**t**ts**C**, if**o**a**n**n**d**y,**i**r**t**e**io**la**n**te**s**d t**(**o**in**th**c**e**lu**co**d**n**e**di**I**ti**C**on**D**f**-**o**9**r w**c**h**o**ic**d**h**e**th**s**e) employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

**Is condition due to injury or sickness arising out of patient’s employment? Is patient still under your care for this condition**?

**Has patient ever had same or similar condition**?

If “Yes” When and Describe

NA Per CBA

**NO**

**YES**

|  |  |
| --- | --- |
|  |  |
|  | **DATE** |
| **Date symptoms first appeared or accident happened.** |  |  |  |
| **Date patient first consulted you for this condition** |  |  |  |

1. **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) |  |
| **If still totally disabled, date patient should be able to return to work.** |  |  |  |

**REMARKS:**

|  |  |
| --- | --- |
| **Patient’s next scheduled visit:** |  |
|  |  |  |

1. **Was patient Hospital confined?**

**YES NO**

If yes, please provide name & address of hospital

1. **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

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Description of Services rendered Pro

**Remarks:**

 Services

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Physician’s Name (print)** | **Signature** |  | **Degree** | THE INFORMA MUST BE FURNISHED UND |
| **Street Address** |  | **State & Zip Code** | INDIVIDUAL PRACTITIONER’S SSN- - |
| **Date** | **Telephone** |  | ALL OTHERS – EMPLOYER I.D. No.- |