Granite School District Fax Number (385) 646-4319

Granite School District
Short-Term Disability Claim Form

STD Claimant's Name:				Employee ID #:
Street/Mailing Address:	City	State	Zip	Home Phone Number ( )
Work Location:				Immediate Supervisors Name:
Is this condition due to: ☐Accident ☐Sickness	Is this disability related to your employment? ☐No ☐ Yes			Date of Contract Hire:
Have you applied for short-term in the last five (5) years? ☐ No ☐Yes If 'Yes' provide last date:	I am a: ☐Teacher ☐ Classified ☐Secretary ☐Administrator			
Describe the injury incurred (what, how, where, when) OR the nature and the medical diagnosis of the sickness and when it began:				
Last Day Worked:	First Contract Day Missed:	Projected Date of Return to Work: (You **MUST** provide date)		

- All disabilities for purposes of short-term or long-term disabilities must have an **ICD-10** or a **DSM-IV-TR** diagnosis.
- Information about the area of specialization of your physician should clearly be stated on the required District Diagnosis and Functional Limitations Form (DFL) and returned with this claim form for short-term disability benefits.
- Granite may seek independent medical verification of your disability.
- Short-term disability benefits will be paid only after ALL accrued sick leave and vacation/personal leave days have been used and after a waiting period without pay. The length of the waiting period without pay depends upon the number of unused sick leave and vacation/personal leave days the employee is able to apply to the short-term disability involved. The length of the waiting period without pay shall be determined by the following formula:

Sick Leave & Vacation/Personal Leave Days Applied to this Short-Term Disability	Waiting Period – Contract Days Without Pay
0 – 5.9	10
6.0 – 10.9	8
11.0 – 15.9	6
16.0 – 20.9	4
21.0 – 40.9	2
41.0 or more	0

With my signature, I acknowledge the following:

- I have received, read and understand Administrative Memorandum #112 outlining the STD guidelines for regular contract employees. http://www.graniteschools.org/hr/wp-content/uploads/sites/19/2014/08/DFL-Form1.pdf
- I am required to submit a current Diagnosis and Functional Limitations (DFL) Form (completed by my attending physician/specialist) with this application in order for my initial STD application to be recognized.
- I have notified my immediate supervisor of my intent to make a claim for STD benefits and together, we have discussed the potential duration of my absence.
- **It is my responsibility to provide the District Human Resource Benefits Office with a renewed DFL every thirty (30) calendar days during my absence from work due to a short-term disability. *Benefit payments shall not be retroactive for any period of time an employee fails to make timely written application or provide other required recertification information. The District is not responsible to remind me of the requirement to provide a new DFL every 30-calendar days.***
- I understand that STD benefits will not be paid beyond 120 calendar days calculated from my first missed contract day and I will only be paid for days within that period designated by the Board as working days.
- I hereby acknowledge that I may experience, as a result of the short-term disability waiting period, some contract days without pay that are not reimbursable under the short-term disability plan.
- With this claim for short-term disability benefits, that I hereby acknowledge that I cannot perform the essential functions of my position with or without reasonable accommodation.
- I understand that the time used for STD benefits will count toward the 12-week FMLA entitlement.

_____ _____
Employee Signature Date

_____ _____
Immediate Supervisor Signature Date

DIAGNOSIS & FUNCTIONAL LIMITATIONS FORM (DFL)

This form is confidential and should only be faxed to: 385-646-4319

TO THE EMPLOYEE:

- → For continuing absence, additional forms must be submitted as per leave policy ***(every 21 calendar days teacher contract; every 30 calendar days administration, and; every 30 calendar days classified)*** or when requested by your principal, supervisor, or the Human Resource Office. ***Doctor's notes are not acceptable.***
- → *Doctor's notes are not accepted. No exceptions. All fields of this form MUST be completed*
- → If filing application for short-term and/or long-term disability benefits, you acknowledge that you cannot perform the essential functions of your job with or without reasonable accommodation.
- → Your signature on this form certifies the accuracy of the information contained herein.
- → Failure to provide this form in a proper and timely manner could result in some loss of leave benefits and/or disciplinary action.

Employee ID#:	Last Name:	First Name, MI	Phone Number
Street Address:	City:	State:	Zip Code:
Current Position:	Work Location:	Supervisor:	Supervisor phone number:

I, the undersigned, authorize the release, to Granite School District, of relevant medical information to determine leave, benefits or return to work eligibility.		Employee's last day worked is/was:
Employee's Signature:	Date:	__ __/ __ __ / __ __

ATTENDING PHYSICIAN'S STATEMENT

DIAGNOSIS

ICD-10/DSM-IV Diagnosis and Code Number:	If pregnancy, est delivery date:	Probable Duration of Condition: Days _____ Weeks _____ Months _____	Was medication prescribed? Yes ☐ No ☐
Date Treated for Condition	Estimated Date of Return	Was the patient referred to another health care provider for evaluation or treatment? ☐ Yes ☐ No *If yes, please provide other physician's contact information:*	

Upon returning to work, can the employee complete the essential functions of their job? ☐ Yes ☐ No	Is this a Worker's Comp claim? ☐ Yes ☐ No

*Upon **returning to work**, please list any restrictions the employee may have*

Actual Date Released to work: _____/ _____ / _____

PHYSICIAN INFORMATION

Printed name of Attending Physician:	Area of Medical Specialty:	
Phone Number:	Fax Number:	Office Hours:
Street Address:	City:	State: Zip Code:
Physician's Signature:		Date:

For Office Use Only: Date received: _____/_____/_____ Email Supervisor: ☐ Update Spreadsheet: ☐ DFL Assigned to: _____