

Healthcare Provider Information

Please provide complete information as it relates to the patient's current medical condition.

Your patient has requested short term disability. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of the current condition, treatment, etc. Your responses should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **Failure to provide a complete and sufficient medical statement or using terms such as "lifetime," "unknown," or "indeterminate" may result in the denial of the employee's STD request.**

Patient / Employee Information

Employee / Patient Name: _____ Phone: _____

Diagnosis

Primary diagnosis code(s): _____ Other related codes: _____

Primary and other related diagnosis: _____

Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such as symptoms, regimen of continuing treatment, therapy, follow-up visits, etc.):

Leave Information

Does the primary or related diagnosis prevent the patient from performing their job functions for at least 10 continuous work days: Yes No

Date of Disability: _____ (Date the **current** disability that prevents the employee from working)

Pregnancy: Date of Delivery: _____ Type of Delivery: Vaginal (6 weeks) Cesarean (8 weeks)

Period of Incapacity (estimate dates of continuous incapacity): _____ to _____
Beginning date End date

Return to Work

Can you determine a return-to-work date? Yes No If no, follow-up on _____
Date

If Yes, Full-time _____ Part-time _____ hours per week until _____
Date Date

The employee may be required to present a written release to return-to-work. If such certification is not received timely, a return may be delayed until the certification is provided.

Statement

My evaluation of the patient's personal medical condition confirms the above information is accurate and complete. I understand that additional medical information may be requested upon the expiration of the period of incapacity specified in the above statement.

Physician's Signature: _____ Date: _____

Printed Name: _____ Specialty: _____

Address: _____ Phone: _____

CSU Human Resources

555 S. Howes Street | Campus Delivery 6004 | Fort Collins, CO 80523-6004
P: 970-491-6947 | F: 970-491-6302 | hr.colostate.edu