SHORE ORTHOPAEDIC UNIVERSITY ASSOCIATES

SHORT-TERM DISABILITY INFORMATION

(Please allow 7-10 business days for completion)

Patient's Name**:** _____ DOB**:**_____

Phone Number or Email for notice of Completion**:** _____

Your Shore Orthopaedic Physician**:**_____

When was (or will be) your first day out of work**?**_____

Approximate date of return**:** _____

If you already returned to work, on what date did you return**?** _____

PLEASE SELECT ONE OF THE FOLLOWING

☐ **Pick Up**: Completed Form(s) *Please select office for pick up*
☐ Somers Point ☐ Galloway ☐ CMCH

☐ **Email**: Completed Form(s) *Please provide your email address*
_____

☐ **Mail**: Completed Form(s) *Please provide a stamped envelope filled out with the address where you would like the form(s) mailed.*

☐ **Fax**: Completed Form(s) *Please provide Fax Number*
(___)_____

Please Note: Once completed you will be notified. However, you are responsible to make sure your forms have been received at the desired location.

$10.00 fee per drop-off: Due to the high volume of requests to complete disability paperwork, it is necessary to charge a drop off fee. Our office recommends dropping off all forms you may need at one time. This fee **WILL NOT** be imposed for NJ State disability Forms, or Handicapped Placards.

**For UNUM, Met-Life or Prudential short-term disability forms, there is a one-time fee of $20.00. This fee will encompass all of the requested updates and records requests during the time your short-term claim is active.*

Authorization to Release Information: I hereby authorize Shore Orthopaedic University Associates to release information to my insurance carrier(s), employer, or others I request concerning my illness and treatments.

Signature of Patient: _____ **Date**: _____