SHORE ORTHOPAEDIC UNIVERSITY ASSOCIATES

SHORT-TERM DISABILITY INFORMATION

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

Phone Number**:** _____

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 allow 7-10 business days for completion – Select one of the following:

☐ **Pick Up:** *Select Office ☐ Somers Point ☐ Galloway ☐ CMCH

☐ **Email:** * Email Address: _____

☐ **Mail**: *Please provide an addressed stamped envelope

☐ **Fax**: * Fax Number: (____) _____

Please note, you are responsible to make sure your form has 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. The fee includes all forms dropped off at the same time.

This fee **WILL NOT be imposed for NJ State Disability Forms or Handicapped Placards.*

List All Forms Dropped Off:

_____ _____

_____ _____

_____ _____

☐ **PAID $** _____ **Initials:** _____

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**: _____