Based on medical verification that an employee’s medical condition meets the serious health condition definition under the Family Medical Leave Act (FMLA), the College provides a percentage of salary continuation for up to the first 180 days of a disability. A completed Physician Statement must be submitted to the Department of Human Resources before the employee goes out on a scheduled leave.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. “Genetic information”, as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

To comply with this law, the College asks that your physician not provide any genetic information when responding to a request for medical information.

No Short-Term Disability payments will be made until the employee has satisfied their waiting period, if any, and submitted a completed Physician Statement. The completed Physician Statement will be reviewed and any work restrictions evaluated. Based on the employee’s job classification, they may be asked to work within the recommended restrictions.

A Transitional Work Program (TWP) exists as a way of bringing an employee back to work within their doctor’s stated work restrictions. The TWP will allow progressive steps to full duty for the employee while providing a safe environment during the recovery process. The TWP is not a long-term program. If the restrictions last longer than 90 days, the employee usually will be placed off work and will not be permitted to return to work until they can perform the essential functions of the position with or without reasonable accommodation, in accordance with all applicable laws.

The completed and submitted Physician Statement does not guarantee that Short-Term Disability will automatically be approved. Short-Term Disability will be approved or denied based on the medical documentation provided, and at the College’s discretion. The employee may be required to submit a second or third opinion at the College’s expense, in accordance with all applicable laws.

Once the employee has met these requirements, and STD has been approved, Payroll will be notified to start payment of Short-Term Disability, based on the salary continuation policy and bargaining unit contracts.

If the leave is unscheduled, a completed Physician Statement must be submitted to the Department of Human Resources in a timely manner. No Short-Term Disability will be paid without a completed Physician Statement; money will be withheld pending compliance with this policy.

If it has been determined by the College that an employee has committed fraud regarding a request for any disability payments, the College will take action to recover any money paid. The employee will be subject to disciplinary action up to and including termination.

Time out on STD will count towards the employee’s FMLA leave.
Pay increases, vacation accrual and sick time accrual will cease during STD, unless required by a collective bargaining agreement, FMLA or other applicable laws, and will not start again until the employee returns to work.

An employee on STD requiring more than 180 days absence from employment MUST apply for Long-Term Disability (LTD). An employee cannot extend Short-Term Disability beyond the 180-day waiting period.

To avoid a lapse in income, the employee should apply for Long-Term Disability at least 30 days prior to the end of Short-Term Disability. Employees who fail to apply and receive LTD in a timely manner may be required to pay the COBRA rate for health insurance and also pay for all applicable employee-paid payroll deductions. Employees who apply and are approved for Long-Term Disability, will pay the LTD premium for health insurance and also pay for all applicable employee-paid payroll deductions. If the employee chooses to participate in health, dental, vision insurance, as well as Flexible Spending Account, Student Accounts office will bill for the premiums on a monthly basis. To continue coverage for optional life, optional AD&D, as well as Long-Term Care insurance for the employee and all covered dependents, a portable benefit application will be mailed to the employee for completion. The employee will have to make premium payments to the LTD carrier directly.

The fact that an employee qualifies as disabled for purposes of this policy does not indicate that the employee is disabled under the American With Disabilities Act (ADA) or other laws or College policies.

The College retains the right to interpret all policy terms, to determine eligibility for benefits, and to modify or eliminate any benefits or terms at its sole discretion, in accordance with applicable law and any applicable bargaining agreements.

7/2014
Under the medical leave policy for Oberlin College, medically disabled employees may be issued a conditional or approved leave of absence based in part on information received from the attending physician or a company-appointed doctor. **It shall be the responsibility of each employee to see that such information is made available on a timely basis and updated as required. Any delay in this information may cause a disruption of your Oberlin College paid benefits. AN APPROVED SHORT TERM DISABILITY LEAVE WILL RUN CONCURRENT WITH FMLA LEAVE.**

**SECTION I** (To Be Completed By The Employee)

**AUTHORIZATION TO HOSPITAL, DOCTOR OR OTHER INSURANCE COMPANY**

I request and authorize you to furnish Oberlin College, or its authorized representative, or to permit the representative to obtain a statement or review or make or obtain a copy, in whole or in part, of any or all information with respect to any illness or injury including but not limited to medical history, diagnosis, consultations, examinations, prescriptions, treatments, operative procedures, x-rays, and pathological findings or tests you may have concerning me. This information is to include alcohol abuse, substance abuse or mental health records. A photocopy of this authorization shall be as valid as the original.

<table>
<thead>
<tr>
<th>Date</th>
<th>Patient Signature</th>
<th>Print Name</th>
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</table>

**SECTION II** (To Be Completed By Physician)

Patient Name: ____________________________________________________

1. Was disability due to occupational accident or occupational sickness? ____________
   If so, please give full particulars ________________________________
   ________________________________
   ________________________________
   ________________________________
   ________________________________

   Has this Injury been filed with Ohio’s Workers’ Compensation? ______ Yes ______ No

2. Date of illness (first symptom), injury (accident) or pregnancy _______________________________
   3. Date first consulted you for this condition: _______________________________

4. Has patient ever had same or similar symptoms? _____Yes _____ No

5. If an emergency, check here ______

6. Is this an aggravation of a pre-existing condition? _____ Yes _____ No

7. If pre-existing when was diagnosis first determined? ______________________________

8. Name of referring physician or other source (e.g. public agency)
   ___________________________________________________________________________

9. Diagnosis (ICD-9 codes) or nature of illness or injury
   1. ______________________________
   2. ______________________________
   3. ______________________________
   4. ______________________________

10. If surgery performed, describe operation ____________________________________________
    ___________________________________________________________________________

11. Give dates on which you attended patient: Date of surgery ______________________________
    At hospital ________________________________
    At office ________________________________

12. Was patient confined in a hospital? _______ Date Admitted ________ Date Discharged ___________
    Name & address of hospital __________________________________________________________________

13. Dates of Disability due to injury/disease? From ______________ To ______________

14. Date of next exam or treatment ________________________________
OBERLIN COLLEGE OCCUPATIONAL RESTRICTIONS

Please review Patient’s job description when listing work restrictions if any. (Description provided by Patient)

Be aware that any restrictions MAY prohibit the Patient from returning to working.

15. In an eight-hour workday, the client can (circle a capacity for each activity)
   Sit  1 2 3 4 5 6 7 8 hours
   Stand 1 2 3 4 5 6 7 8 hours
   Walk 1 2 3 4 5 6 7 8 hours

16. Patient is able to:
   Not at All Occasionally Frequently Continuously
   Bend/Stoop
   Crawl
   Climb
   Reach Above Shoulder Level
   Kneel
   Push/Pull

17. Patient can carry/lift unassisted:
   Not at All Occasionally Frequently Continuously
   Up to 10 pounds
   11 - 20 pounds
   21 - 30 pounds
   31 - 40 pounds
   41 - 50 pounds
   51 - 60 pounds
   > 61 up to 100 pounds
   *Can Patient carry/lift with assistance:

18. Given the Patient’s condition and/or medication, can he/she operate a moving vehicle and/or power equipment safely and responsibly? _____ Yes _____ No

19. Patient can use hands for repetitive action such as:
   Simple Grasping Right hand ____ Yes ____ No Left hand ____ Yes ____ No
   Firm Grasping Right hand ____ Yes ____ No Left hand ____ Yes ____ No
   Fine Manipulating Right hand ____ Yes ____ No Left hand ____ Yes ____ No

20. Patient can use head and neck in:
   Static Position ____ Yes ____ No
   Frequent Flexing ____ Yes ____ No
   Frequent Rotating ____ Yes ____ No

21. Restriction of activities, such as being around moving equipment or driving:

22. Date Patient able to return to work with above restrictions ____________________ □ Estimated □ Actual

23. Date Patient able to return to work without restrictions ______________________ □ Estimated □ Actual

24. Physician or provider’s name, address and telephone number:

25. Physician’s Phone Number (          )_____________________________________

26. Physician’s Provider Number _____________________________________________

27. Physician’s Printed Name ________________________________________________

28. Signature of Physician: ___________________________________________ Date___________

To be completed by the Department of Human Resources – Short Term Disability is:

Approved/Denied/Additional Information Required: ____________________________ Signed: __________ Date: __________

Rev., 05/03, 11/10, 1/11 Confidential Fax to 440-775-8438 Department of Human Resources Phone 440-775-8430