

Sandia National Laboratories

INSTRUCTIONS FOR COMPLETING PHYSICIAN'S CERTIFICATE OF DISABILITY (PCD)

Note 1: See Sickness and Accident Plans Summary – Summary Plan Description, Effective January 1, 2007

INSTRUCTIONS TO MANAGER:

1. The immediate manager of an employee who has been absent due to illness for two (2) consecutive calendar days, and anticipates the absence could meet criteria in #2 below, should complete the top portion of the Physician's Certificate of Disability (PCD) [SF 4560-G (05-02)] and send it with the return envelope [SA 4560-H (2-99)] to the employee by the third day of absence. In the event of scheduled surgery or other scheduled treatment, the manager may provide the employee this form and envelope in advance of the anticipated absence.
2. A copy of this form (prior to being completed and containing privileged medical information) may be retained for department files.

INSTRUCTIONS TO EMPLOYEE:

Sickness absence benefits provide for temporary disability for diagnosed medical conditions with a goal of assisting employees in successfully returning to work. To qualify for paid sickness absence benefits, please follow these instructions: Note: in this form, HBE refers to the Health, Benefits, and Employee Services Center (in NM) or to the HBE Department (in CA.)

1. **You must ensure that the top portion of this form is completed including signing the authorization for release of information.** This authorization grants permission to your health care provider to provide supportive medical information for this absence only and will be used to determine eligibility for sickness absence benefits.
2. **You must be seen by your personal physician or an Urgent Care facility within the first five consecutive workdays or seven consecutive calendar days of absence.** If your absence meets the above criteria, you must have your physician complete this form certifying that you were under his/her care and unable to work because of illness. During lengthy absences, you may be required to submit additional PCDs or medical documentation to support the absence, be requested to sign a release for medical information, or be requested to report to the Health Services Clinic. For SNL/CA employees who are eligible to file a State Disability Insurance (SDI) claim, the "Doctor's Certificate" (page 3) of the State Claim form (DE2501) will be accepted in lieu of a PCD.
3. **The PCD must be received in the HBE within 14 calendar days of the first date of absence.** The SNL HBE and/or the employee's manager may require a PCD for absences of shorter duration than five consecutive workdays or seven consecutive calendar days when in its opinion circumstances warrant.
4. The PCD must be acceptable to the HBE or sickness absence benefit time may be denied. The diagnosis and treatment of the physician or health care practitioner completing this form must be within the scope of their practice and should normally be completed by a Doctor of Medicine (MD), or Doctor of Osteopathy (DO). PCDs are accepted from other health care practitioners only in the following limited situations:
 - a. Chiropractors: Certificates are accepted only for spinal-muscular problems with symptom(s) and signs directly in the back and are not accepted for other health problems, the symptoms and signs of which are in other parts of the body, whether or not attributed to the back by the practitioner.
 - b. Dentists: For any absence involving dental care or treatment which disables you from working. Routine visits for fillings, cleaning, minor extractions or other treatment of similar nature are not considered disabling.
 - c. Podiatrists: Certificates are accepted only when treatment is appropriate for the disability.
 - d. Certified Nurse Practitioner and Physicians' Assistant: Certificates are accepted only when the treatment is appropriate for the disability and it falls within national disability guidelines for recovery.
 - e. Certified Nurse Midwives: For any absence involving normal/ uncomplicated obstetrics and delivery.
 - f. Licensed Mental Health Professional (e.g. Psychiatrist, Licensed Psychologist, Licensed Professional Counselor). For any absence associated with behavioral health diagnosis.
5. You do not have to bring this completed certificate with you in order to return to work. The physician or health care practitioner can fax the PCD to (505) 845-8190 (SNL/NM), (925) 294-2392 (SNL/CA) or mail it to the HBE in the self-addressed envelope.
6. You are responsible for returning to work by the date specified on the PCD and approved by the HBE or submitting a new or modified PCD (or other acceptable medical documentation) before the original approved return-to-work date has expired.
7. You **must** return to work through the Health Services Clinic if you: (1) were hospitalized; (2) underwent a surgical procedure; (3) were absent because of a work-related illness or injury; (4) were absent due to heart or psychiatric conditions; (5) wear a dosimeter and have undergone a nuclear medicine procedure; (6) were evaluated by an outside facility for a potential exposure; (7) were absent more than 40 hours in one month; (8) were absent as a result of any injury or treatment that might effect your job performance; (9) were requested by your manager to do so; (10) were requested by the HBE to do so; or (11) you were absent five consecutive workdays or seven consecutive calendar days
California employees may call the Telephonic Return to Work contact at (925) 294-2700 (SNL/CA) to determine whether they can be approved to return-to-work over the phone or need to visit the Health Services Clinic for approval.
8. **You must obtain the approval of the HBE before you: a) leave town during sickness (for any reason), including medical treatment and/or testing, or b) start a scheduled vacation immediately following sickness absence. Routine medical visits or treatments between neighboring cities do not require HBE approval.**
9. It is your responsibility to discuss the return to work date (as stated on the attached certificate) with your treating physician or health care practitioner and your manager.
10. DOE Order 472.1c requires that DOE clearance access authorizations "be terminated when an individual is on leave of absence or on extended leave and will not require access for at least 90 days." (Note: this includes 90 consecutive calendar days of sickness absence). Prior to the employee's expected return to work, the badge office must be notified by the Manager to request clearance access reinstatement. If reinstatement is not completed prior to the employee's return, she/he will receive an uncleared access badge and be escorted until the reinstatement is complete.
11. Absences associated with paid and approved sickness absence benefits meet the requirements of the Family and Medical Leave Act (FMLA) for personal sickness. **If you are eligible under the FMLA this absence will count towards your FMLA entitlement.** Refer to site: http://www.sandia.gov/benefits/spd/pdfs/FMLA_Fact_Sheet.pdf Questions and/or information regarding —call the HBE Customer Service, 844-4237.
In California, call Health, Benefits, and Employee Services Department 8527 (MS 9112), 294-2700.

Sandia National Laboratories PHYSICIAN'S CERTIFICATE OF DISABILITY (PCD)

THIS PORTION COMPLETED BY EMPLOYEE/ EMPLOYEE'S ORGANIZATION

Date Originated		Employee's Name		First Day of Absence
Social Security Number		Address (Street, City, and State)		Home Telephone Number
Org. No.	Mail Stop	Date of Birth	Manager's Name and Phone No.	Represented <input type="checkbox"/> Yes <input type="checkbox"/> No
Was this illness/injury the result of an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No			What was the cause of that accident? Briefly describe. (e.g. MVA, fall, fire, etc.)	

Authorization for Release of Information (Signature is Required)

I authorize any physician, medical practitioner, health care practitioner, hospital, Veterans Administration hospital, clinic, other medical or medically related facility having information as to diagnosis, treatment, and prognosis with respect to any physical or mental condition, and/or treatment of me related to this absence/illness **only**, to provide Sandia National Laboratories' Health Services Center any and all such information.

I understand that the information obtained by use of this Authorization will be used by Sandia National Laboratories' Health Services Center to determine eligibility for benefits. I understand that I have the right to revoke this authorization in writing at any time. This authorization will expire on _____ or one year from date of signature.

Employee's Signature _____ Date _____

THIS PORTION COMPLETED BY EMPLOYEE'S PHYSICIAN

**TO
PHYSICIAN**

Sickness absence benefits provide for temporary disability for diagnosed medical conditions, with a goal of assisting employees in successfully returning to work. An employee must be considered unable to work because of sickness or injury, as certified by the employee's physician, **before** sickness benefits can be paid to the employee. If the employee's absence attributed to sickness is not approved sickness benefit time may be denied. During lengthy absences, additional Physician's Certificates or medical treatment records may be requested. If you have any questions, please contact the Health Services Center at 844-4237 (SNL/NM) or 294-2700 (SNL/CA). **Please keep a copy for your patient medical records.**
Thank you for your cooperation. Edward B. Cazzola, M.D., Medical Director

TREATMENT DATES	Date First Seen During This Absence	Date Last Seen During This Absence
DIAGNOSIS	(Include complications if any)	ICD9 Code
SURGERY	Date	Type of Surgery
HOSPITALIZATION	Date(s)	Name of Hospital
WORK LIMITATIONS	<p>Sandia can normally accommodate restricted physical activity and/or varied work schedule to aid in rehabilitation. If any recommendations of this type are necessary, please indicate type and duration of need in space below.</p> <p>_____</p> <p>_____</p> <p>Do you wish a Sandia National Laboratories' physician to contact you regarding rehabilitation of this employee? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
RETURN TO WORK	<p>It is the Responsibility of the Employee to Discuss the Return-To-Work Date with the Physician.</p> <p style="text-align: center;">Physician Give Date Employee May Return to Work. →</p>	
ATTENDING	Name	Date Employee May Return to Work
	Address	Telephone No.

I CERTIFY that the patient has been unable to work from the first day of absence (see top of form) to the indicated return-to-work date, or is still unable to return to work.

Signature _____

Physician's Signature

Date

RETURN TO SNL HEALTH SERVICES DEPARTMENT

New Mexico:

P.O. Box 5800 MS 1019
Albuquerque, NM 87185-1019
FAX (505) 845-8190

California:

P.O. Box 969 MS 9112
Livermore, CA 94551-0969
FAX (925) 294-2392

THIS PORTION FOR SNL HEALTH SERVICES USE ONLY

Date Received	Approved Until <input type="checkbox"/> Extension of existing PCD	MCM Initials	Guidelines MDA <input type="checkbox"/> Work Loss <input type="checkbox"/>	Date EE & Mgr Notified	Data Entered (Date)	IT Initials
Notes						