



ADMINISTRATIVE PROCEDURES

Procedure Number: 23-8

Effective Date: 03/01/1999

Revision Date: 10/03/2012

C. Duliet
County Administrator

SUBJECT: **LONG TERM DISABILITY (LTD) PROGRAM**

DEPARTMENT RESPONSIBLE: **Human Resources Department**

I. **STATEMENT**

The purpose of this procedure is to assist departments in initiating Long Term Disability for an eligible employee who will be off work longer than six months due to an illness or injury.

II. **ELIGIBILITY CRITERIA**

A. Eligible Employees

1. Any employee who is a member of the Arizona State Retirement System (ASRS); and
2. The employee's illness or injury occurred while employed by Pima County; and
3. The employee is under the care of a licensed physician; and
4. The employee is unable to perform one or more of the job duties for which he/she was hired.

B. Ineligible Employees

1. Active plan members from the Public Safety Personnel Retirement System, the Elected Officials Retirement Plan, the University Optional Retirement Plan or the Correction Officers' Retirement Plan.
2. A participant who is already receiving retirement benefits from ASRS.
3. A participant who withdraws employee contributions with interest and ceases to be a member of the plan.
4. A participant who files an initial claim for disability benefits more than twelve months after the date of disability, unless they can show good cause for filing late.

III. PROCEDURES

A. Initial Contact Requirements

1. When the employee has been unable to work due to sickness or injury or has been working limited duty/hours and/or restrictions for “two consecutive months”, it is the Department’s responsibility to notify Human Resources Benefits Division to send out the Long Term Disability Plan Benefits information to the employee.
2. The employee may apply for Long Term Disability as soon as he/she is aware that his/her disability may result in him/her being off work longer than six months.
3. If the employee chooses to apply for Long Term Disability after reviewing the LTD Plan Benefit information, he/she must contact Human Resources to request the LTD claim packet. (Attachments B-1 through B-8)
4. The employee must satisfy the six-month waiting period as follows:
 - a. Off work during a six-month waiting period; or
 - b. Working in a less strenuous occupation (restructured/modified duties) as deemed by a licensed physician; or
 - c. Working 20 hours or less per week. The employee may use annual or sick leave and, if eligible, receive donated time during the waiting period.
 - d. Refer to Administrative Procedure 23-4 Leave of Absence – Insurance Procedures, for election and payment of health and life insurance.

B. Application for Long Term Disability – Department

1. “Long Term Disability Income Plan, Employer’s Notice of Claim” form and Physical / Non Physical Aspects of Job (Attachment A) – the department Director or designee must complete this form and supply the requested information. A signature of the person completing the form is required.
2. “Job Description and Requirements” – In cases where the employee is/was working modified duties/hour and/or restrictions, a memo with a description of the modified duties/hours and/or restrictions the beginning and ending dates the modified duties are/were being performed must be submitted.
3. Submit any documentation in the employee’s file from physicians excusing the employee from work, reducing hours or modifying duties in relation to the disability.

IV. RESPONSIBILITIES**A. Department shall:**

1. Notify Human Resources to send out the Long Term Disability Plan Benefit information no later than two months of an employee being unable to work due to sickness or injury or has been working limited duty/hours
2. Complete the Long Term Disability Employee's Notice Claim forms within ten (10) working days.
3. Return the forms and requested information to the Long Term Disability representative in Human Resources Benefits.

B. Employee shall:

1. Contact Human Resources to request the Long Term Disability claim packet.
2. Submit all completed Employee Claim Forms (Attachments B1 through B8) to the Long Term Disability Representative in Human Resources Benefits.
3. Immediately resign from County employment upon receiving approval notification of his/her Long Term Disability coverage.
4. The Long Term Disability employee may be eligible for a Premium Benefits (subsidy) reimbursement from one ASRS. In this case, the LTD participant will need to notify Human Resources if health benefits are continued under Consolidated Omnibus Budget Reconciliation Act (COBRA).

C. Human Resources Benefits shall:

1. Inform the employee of the eligibility and waiting period requirements for Long Term Disability
2. Assist the employee in completing the necessary forms.
3. Obtain the official County Job Classification Specification to be submitted with Long Term Disability application.
4. Obtain copies of all Time and Attendance Forms (TAF's) from Central Payroll from the date of disability through the date of submission to the Long Term Disability Administrator.
5. Compile forms, verify information, and send the application to the ASRS Long Term Disability Administrator.
6. Notify the department when a decision has been reached regarding the application.

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7. Notify the employee and advise of the COBRA process for health insurance continuation.
 8. Notify the appropriate State retirement system, if the LTD member elects COBRA and makes the first payment, to determine eligibility for Premium Benefit (subsidy) reimbursement.
 9. After the County has received the subsidy payment from the retirement system, the County will reimburse the LTD member the subsidy amount provided the LTD member has made the COBRA premium payment in full.

ARIZONA STATE RETIREMENT SYSTEM LONG-TERM DISABILITY INCOME PLAN EMPLOYER'S NOTICE OF CLAIM						
 sedgwick.		Employer's Notice of Claim Be sure to answer all questions Please type or print Fax completed forms to: (818) 591 7664			MAILING ADDRESS SEDGWICK P.O. Box 9830 Calabasas, CA 91372 - 0830	
TO BE COMPLETED BY THE EMPLOYER						
						New claim: <input type="checkbox"/> Yes <input type="checkbox"/> No
1. Full name of employee (Please print)		2. Date employed		3. Effective date of protection under ASRS plan		
4. Social Security number		6. Employee's normal work schedule in a fiscal year A. Period(s) covered by contract _____ B. ___ Days per week ___ Hours per day If you are a school district, has claimant signed a contract for the next school year? <input type="checkbox"/> Yes <input type="checkbox"/> No Number of Pay periods per year _____				
5. Amount of salary as of date disability began for purpose of ASRS: \$ _____ Gross Monthly Salary (If school district give 1/12 th of the annualized compensation)		7. Date last worked (no. of hours that date) _____ hrs		8. Reason for not working after this date		9. Date disability began
10. Did this disability occur as a result of the claimant's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently disputed If "Yes," or under dispute, please provide us with the policy number, name, address and phone number of Workers Compensation administrator						
11. Have you and the claimant discussed reasonable accommodations which would allow a return to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" please explain.						
12. Has employee resigned or been terminated? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" please give exact date:						
13. Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Regular duties <input type="checkbox"/> With restrictions If "Yes" on what date?			Current work schedule: Days per week _____ Hours per day _____			
14. Has the employee ever made a prior claim for benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes" please provide date returned to work.)		15. Sick leave end date		16. Vacation pay end date		
17. Is the employee receiving donated leave? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" please indicate how much they are receiving per pay period: _____ and the end date:						
18. Is the employee receiving Short - Term Disability or Mid Term Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," are the premiums paid by the <input type="checkbox"/> Employee or <input type="checkbox"/> Employer? If by the employer, please complete Question 19.						
19. To the best of your knowledge, is the employee receiving, or is he entitled to receive, benefits from any other source such as a salary - continuance plan, other group insurance, Workers' Compensation, Social Security, Veterans Administration, retirement or pension plan, etc? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please furnish the following information:						
Name and Address Of Source	Group or Individual Basis	Policy or Claim Number, If Any	Exact Date Benefits Commenced or Will Commence	Length of Benefit Period	Amount and Frequency of Each Periodic Benefit	Total Amount of Benefits Paid
20. Remarks						

Client / Plan No. 401 / 401000 Employer Name _____

ASRS Employer No. _____ Contact/Title _____

Telephone No. _____ Signature _____

Fax No. _____ Date _____

E-mail Address _____



**Employer Claim Statement – Part 2
Physical / Non Physical Aspects of Job**

Please complete this section of the claim statement to provide us with information concerning the physical / non physical demands of the claimant's job.
 Claimant's Occupation _____
 Signature / Title _____ Date: _____

Physical Requirements

1. In a typical work day, give the number of hours the claimant spends in each of these positions and if claimant may alternate positions:

Position	Total No. Hours	At Will	May Alternate Positions		
			15-30 Minutes	Hourly	Never
Sitting	—	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	—	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	—	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	—	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Claimant must	Never	Occasionally (¼ - 2 ½ hours)	Frequently (2 ½ - 5 ½ hours)	Continuously (5 ½ - 8 hours)
A. Bend/Stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Reach above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Enter data/keystroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Lift: Usual — lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Max — lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Carry Usual — lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Max — lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. Push/Pull Usual — lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Max — lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. On the job, claimant uses feet repetitive movements as in operating foot controls.
 Right Yes No Left Yes No Both Yes No
4. On the job, claimant uses hands for repetitive action such as:
 Simple Grasping Firm Grasping Fine Manipulation
 A. Right
 B. Left
5. Does job require:
 A. Working at unguarded heights? Yes No
 B. Exposure to marked changes in temperature and humidity or extremes thereof? Yes No
 C. Exposure to dust, fumes, gases, chemicals? Yes No

Stress / Non Physical

- Percentage of time claimant spends answering customer complaints. ___ %
- Percentage of claimant's work primarily judged on production. ___ %
- Does this claimant depend upon the assistance of others in order to accomplish his/her daily tasks? Yes No ___ % of time
- How many employees does this claimant supervise? _____
- Is this claimant routinely subject to close supervision? Yes No
- Percentage of time spent by the claimant working with his/her co-workers. ___ %
- Percentage of claimant's time spent on: ___ % Prescheduled activities ___ % Random activities
- Percentage of time claimant spends meeting deadlines set by others. ___ %
- Percentage of responsibility the claimant has for the performance of his/her particular department. ___ %



Long Term Disability Employee Claim Statement



TO BE COMPLETED BY THE EMPLOYEE		New claim: <input type="checkbox"/> Yes <input type="checkbox"/> No	
1. Full name of employee (Please print) <input type="checkbox"/> Male <input type="checkbox"/> Female		2. Date of Birth	3. Social Security number
4. Nature of sickness or injury (if do to accident, explain when, where and how it happened)		5. Employer	
7. Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced		6. Occupation	
9. Date on which you were first unable to work		8. Names and birth dates of spouse and of all dependent children under age 18	
10. Date of first medical treatment for the condition If pregnancy, provide expected or actual delivery date.		11. Have you engaged in any work, part-time or otherwise, since your sickness or injury began? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes" please explain and give dates.)	
12. If still totally disabled, when do you expect to return to work?		13. If you have recovered or returned to work, give date.	
14. Have you been confined to a hospital for this disability? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes" please complete.) Name of Hospital City From Through			
15. Names and addresses of all physicians who have been consulted because of this condition (attach additional sheets, if necessary) Name Address Dates of Consultation or Treatment			
16. Are you receiving or have you applied for benefits from any of the following?		Yes	No
1. Social Security Disability?		<input type="checkbox"/>	<input type="checkbox"/>
2. Social Security Retirement?		<input type="checkbox"/>	<input type="checkbox"/>
3. Sick pay/Vacation pay from your employer?		<input type="checkbox"/>	<input type="checkbox"/>
4. Arizona State Retirement System?		<input type="checkbox"/>	<input type="checkbox"/>
5. Veterans Administration?		<input type="checkbox"/>	<input type="checkbox"/>
6. Workers Compensation?		<input type="checkbox"/>	<input type="checkbox"/>
7. Short Term Disability?		<input type="checkbox"/>	<input type="checkbox"/>
8. Unemployment Benefits?		<input type="checkbox"/>	<input type="checkbox"/>
9. Other?		<input type="checkbox"/>	<input type="checkbox"/>
For each question answered "Yes" please furnish the following information:			
Name and Address of Source	Group or Individual Basis	Policy or Claim Number if any	Exact Date Benefits Commenced or Will Commence
			Length of Benefit Period
			Amount and Frequency of Each Periodic Benefit
			Total Amount of Benefits
For Social Security, Workers' Compensation, State Disability and other similar benefits, please furnish a copy of the benefit award (or denial letter, if applicable.)			

(Do not complete this section if you have returned to work, or if disability is for pregnancy.)

Training, Education & Experience

(For the possible exploration of Rehabilitation services, please complete the following.)

17. What is your level of education?
A. Have you received a high school diploma or the equivalent of a high school diploma? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No, please advise us of the last grade completed. _____ grade
B. Have you attended college? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please check one: <input type="checkbox"/> Some college <input type="checkbox"/> College graduate <input type="checkbox"/> Post graduate Please specify: Major field of study _____ Degree earned _____ Date last attended _____
C. Have you attended any trade schools or received any other special training? <input type="checkbox"/> Yes <input type="checkbox"/> No Please specify: Type of training _____ Date last attended _____
18. Please list all previous occupations and the dates worked for each occupation. Please attach a copy of your resume, if available.



Sedgwick CMS AUTHORIZATION FOR RELEASE OF INFORMATION (ROI)

YOUR CLAIM FOR DISABILITY BENEFITS CANNOT BE PROCESSED WITHOUT THIS FORM

Employee Name:		Date of Birth:
Employer Name: Arizona State Retirement System		
Plan Number: 401000	Plan Name: Arizona State Retirement System – LTD	
Last Date Worked:	First Date Unable to Work:	Date:
<p>COMPLETE THE STEPS BELOW AND RETURN THIS FORM TO SEDGWICK CMS IMMEDIATELY:</p> <p>STEP 1: Please complete the information above and then sign and date in the spaces provided below.</p> <p>STEP 2: You should also provide a copy of this form to your doctor's office as they may require a copy of this form in order to provide SEDGWICK CMS information regarding your disability. Failure to complete this completed form can impede the investigation or processing of your claim and may result in a delay or denial of benefits.</p> <p>If you have questions regarding your claim, visit us on the web at www.SEDGWICK CMSinc.com or call us at (800)495-9301.</p>		

CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

I certify all of the information above (except as corrected) is to the best of my knowledge true, correct and complete. I hereby authorize the use or disclosure of my personal health information upon request by SEDGWICK CMS, Inc. from the following authorized persons or organizations: Workers' Compensation Carrier, Long-Term Disability Carrier, and Health Carrier. I hereby further authorize the above persons or organizations, any physician, medical practitioner, hospital, clinic, other medical or medically related facility, pharmacy, insurer, claims administrator, and my employer(s) to disclose or furnish to SEDGWICK CMS, my employer, or any of their authorized representatives, all facts concerning my medical condition and disability (including physical, mental health, alcohol, substance abuse and HIV related information), wages or earnings, that are within their knowledge and to allow inspection of and provide copies of any medical records (including diagnosis, prognosis, prescriptions or medication, psychiatric, drug or alcohol abuse treatment). I understand that this information will be used to determine my eligibility for benefits or compensation to which I may be entitled under any benefit plan or practice of my employer, which requires evaluation for physical or mental condition, including, but not limited to, a leave from work for medical reasons. I further authorize disclosure of my personal health information to others by SEDGWICK CMS, my employer, or any of their authorized representatives, in order to determine my eligibility for, process, evaluate and administer all claims for benefits or compensation for which I may be entitled. I acknowledge my right to make a copy of this authorization. I understand this authorization is valid for the duration of my claim for disability benefits or twenty-four months, whichever is earlier. A photocopy of this authorization is as valid as the original.

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.

IMPORTANT INFORMATION ABOUT YOUR RIGHTS

I may revoke this authorization at any time before its expiration date by notifying SEDGWICK CMS, Inc. in writing, but the revocation will not have any affect on any actions the party took before it received the revocation. I understand that my personal health information may be released to others in accordance with the terms of this release.

Employee's Signature

Date Signed

Name of Personal Representative who has Authority to Sign on Behalf of the Employee

Signature of Personal Representative who has Authority to Sign on Behalf of the Employee



**Employee Consent To Pima County's Disclosure of Employment
Information and Release of Liability**

I, _____ (print name), authorize and give my consent for Pima County Government (PCG) to release any information regarding my education, training, experience, and job performance, including, but not limited to, the reason for any termination, professional conduct and evaluation, if contacted by:

Provide name of specific carrier:

Sedgwick
Humana Life Insurance

Or:

Any prospective employer (initial if desired) _____

According to Arizona Revised Statutes §23-1361, a copy of which appears on the reverse side, any employer that provides written communication regarding my current employment must send me a copy at my last known address. I acknowledge that some supervisors may be unwilling to provide factual written references concerning a current or past employee unless they may do so confidentially, without revealing the references to the employee.

I waive ___/do not waive ___ (initial only one) my right to receive a copy of any written communication furnished by PCG.

Whether or not I have waived my right to see or to receive copies of written references furnished by PCG, I release, hold harmless and agree not to sue or file any claim of any kind against PCG or any current or former officer, agent or employee of PCG, who in good faith, furnishes written or oral references to a prospective employer.

A photocopy or facsimile ("fax") copy of this form that shows my signature shall be as valid as an original.

Current/Prior Employee

Date

Address: (if a copy of written communication is desired)

(Street, PO Box, or Apartment number)

City, State, Zip Code)

STANDARD AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This form is not valid for pre-enrollment activities.

<p>NAME OF MEMBER WHOSE PROTECTED HEALTH INFORMATION WILL BE DISCLOSED: Last Name, First Name (please print): _____ Member SS Number: _____</p>
<p>MEMBER INFORMATION TO BE USED OR DISCLOSED <input type="checkbox"/> By checking this box, I allow the person noted below to act upon and/or make changes to my member information (i.e., primary care physician change, change in network, residential address/telephone change*). <input type="checkbox"/> By checking this box, I allow for only use and disclosure of the following member information (i.e., certain claims from a provider with specified dates of service, all information held by the insurer, etc.). Please list: <u>Employment, Payroll, Medical Information</u> *Only address and telephone changes in the same county will be accepted from member with this form. Important: This authorization excludes enrollment and disenrollment purposes in which case a valid Power of Attorney must be on file.</p>
<p>NAME OF PERSON TO WHOM THE INFORMATION WILL BE DISCLOSED: Last Name, First Name (please print): _____ If the disclosure is intended for a class or group of individuals rather than a specific individual, please indicate that here (for example, the staff of an office, a company, etc.): <u>Pima County / ASRS Long Term Disability Administrator / Life Insurance Carrier</u></p>
<p>EXPIRATION: This authorization is valid from _____ to _____ or for the period of time or event noted below (for example, an event might be as long as the member remains a member). _____</p>

REVOCAION OF AUTHORIZATION: As stated in Pima County Notice of Privacy Practices, you have the right to revoke this authorization except for instances that have already taken action based on the authorization. Your revocation must be mailed to:

Human Resources
 150 W. Congress, 4th Floor Benefits
 Tucson, AZ 85701

You may also notify the Human Resources department by calling 520-740-8464 during normal business hours and request to revoke this authorization.

CONSEQUENCES OF THIS AUTHORIZATION: Please be advised that once Member Information is disclosed to the authorized individual, there is a potential for it to be re-disclosed by the recipient and no longer protected.

By signing below, I am indicating that, at my request, I am voluntarily agreeing to allow Human Resources employees whose duties involve handling the member information indicated above to disclose my confidential member information to the person designated above. I understand that Human Resources may not condition (withhold) treatment, payment, enrollment, or eligibility of benefits as a result of this authorization.

<p>SIGNATURE(S): Signature of Member: _____ Signature Date: _____</p>

If you are a lawful personal representative of the member and are acting on his/her behalf, please sign below.

<p>NAME OF CUSTOMER OR REPRESENTATIVE (IF APPLICABLE): Last Name, First Name (please print): <u>Shimok, Pamela</u> Signature of Custodian or Representative: <u>Pamela Shimok</u> Signature Date: _____</p> <p>Description of Authority to act on behalf of the member: (for example, Power of Attorney on file or legal guardian of minor): <u>Pima County Long Term Disability Representative</u></p>
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Form W-4 (2012)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2012 expires February 18, 2013. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$950 and includes more than \$300 of unearned income (for example, interest and dividends).

Basic instructions. If you are not exempt, complete the Personal Allowances Worksheet below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the Personal Allowances Worksheet below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity

income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1382, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2012. See Pub. 505, especially if your earnings exceed \$130,000 (single) or \$160,000 (married).

Future developments. The IRS has created a page on IRS.gov for information about Form W-4, at www.irs.gov/w4. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted on that page.

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for yourself if no one else can claim you as a dependent A
B Enter "1" if:

- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. B

C Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) C
D Enter number of dependents (other than your spouse or yourself) you will claim on your tax return D
E Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above) E
F Enter "1" if you have at least \$1,900 of child or dependent care expenses for which you plan to claim a credit (Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.) F
G **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.
• If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then less "1" if you have three to seven eligible children or less "2" if you have eight or more eligible children.
• If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child G
H Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) ▶ H
For accuracy, complete all worksheets that apply.

- If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2.
- If you are single and have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$10,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld.
- If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.

Separate here and give Form W-4 to your employer. Keep the top part for your records.

Form W-4 Employee's Withholding Allowance Certificate OMB No. 1545-0074
2012
Department of the Treasury Internal Revenue Service
Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.
1 Your first name and middle initial Last name 2 Your social security number
Home address (number and street or rural route) 3 Single Married Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code 4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2) 5
6 Additional amount, if any, you want withheld from each paycheck \$ \$
7 I claim exemption from withholding for 2012, and I certify that I meet both of the following conditions for exemption.
• Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and
• This year I expect a refund of all federal income tax withheld because I expect to have no tax liability.
If you meet both conditions, write "Exempt" here 7
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.
Employee's signature (This form is not valid unless you sign it.) ▶ Date ▶
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS) 9 Office code (optional) 10 Employer identification number (EIN)
For Privacy Act and Paperwork Reduction Act Notice, see page 2. Cat. No. 102200 Form W-4 (2012)

Form W-4 (2012) Page 2

Deductions and Adjustments Worksheet

Note. Use this worksheet only if you plan to itemize deductions or claim certain credits or adjustments to income.

- Enter an estimate of your 2012 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. 1 \$ _____
- Enter: $\left\{ \begin{array}{l} \$11,900 \text{ if married filing jointly or qualifying widow(er)} \\ \$8,700 \text{ if head of household} \\ \$6,950 \text{ if single or married filing separately} \end{array} \right.$ 2 \$ _____
- Subtract line 2 from line 1. If zero or less, enter "-0-". 3 \$ _____
- Enter an estimate of your 2012 adjustments to income and any additional standard deduction (see Pub. 503). 4 \$ _____
- Add lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2012 Form W-4 worksheet* in Pub. 505.) 5 \$ _____
- Enter an estimate of your 2012 nonwage income (such as dividends or interest). 6 \$ _____
- Subtract line 6 from line 5. If zero or less, enter "-0-". 7 \$ _____
- Divide the amount on line 7 by \$3,900 and enter the result here. Drop any fraction. 8 _____
- Enter the number from the *Personal Allowances Worksheet*, line H, page 1. 9 _____
- Add lines 8 and 9 and enter the total here. If you plan to use the *Two-Earners/Multiple Jobs Worksheet*, also enter this total on line 1 below. Otherwise, stop here and enter this total on Form W-4, line 5, page 1. 10 _____

Two-Earners/Multiple Jobs Worksheet (See Two earners or multiple jobs on page 1.)

Note. Use this worksheet only if the instructions under line H on page 1 direct you here.

- Enter the number from line H, page 1 (or from line 10 above if you used the *Deductions and Adjustments Worksheet*). 1 _____
- Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. However, if you are married filing jointly and wages from the highest paying job are \$65,000 or less, do not enter more than "3". 2 _____
- If line 1 is more than or equal to line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. Do not use the rest of this worksheet. 3 _____

Note. If line 1 is less than line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

- Enter the number from line 2 of this worksheet. 4 _____
- Enter the number from line 1 of this worksheet. 5 _____
- Subtract line 5 from line 4. 6 _____
- Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here. 7 \$ _____
- Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding needed. 8 \$ _____
- Divide line 8 by the number of pay periods remaining in 2012. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2011. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck. 9 \$ _____

Table 1				Table 2			
Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$5,000	0	\$0 - \$5,000	0	\$0 - \$70,000	\$570	\$0 - \$35,000	\$570
5,001 - 12,000	1	5,001 - 15,000	1	70,001 - 125,000	690	35,001 - 60,000	\$60
12,001 - 22,000	2	15,001 - 25,000	2	125,001 - 190,000	1,060	60,001 - 170,000	1,060
22,001 - 30,000	3	25,001 - 35,000	3	190,001 - 340,000	1,250	170,001 - 375,000	1,250
30,001 - 40,000	4	35,001 - 45,000	4	340,001 and over	1,330	375,001 and over	1,330
40,001 - 48,000	5	45,001 - 60,000	5				
48,001 - 55,000	6	60,001 - 80,000	6				
55,001 - 65,000	7	80,001 - 95,000	7				
65,001 - 72,000	8	95,001 - 120,000	8				
72,001 - 85,000	9	120,001 and over	9				
85,001 - 97,000	10						
97,001 - 110,000	11						
110,001 - 120,000	12						
120,001 - 135,000	13						
135,001 and over	14						

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(b)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to state, state, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

**ARIZONA FORM
A-4**

**Employee's Arizona Withholding
Percentage Election**

2010

NOTE: This form is effective for wages paid after June 30, 2010.

Type or print your full name	Your social security number
Home address (number and street or rural route)	
City or town, state, and ZIP code	

Arizona Withholding Percentage Election Options

Choose only one:

- 1 My annual compensation is \$15,000 or more. I choose to have Arizona withholding at the rate of (check only one box): 1.8% 2.7% 3.6% 4.2% 5.1% of my gross taxable wages.
Additional amount to be withheld per paycheck \$ _____
- 2 My annual compensation is less than \$15,000. I choose to have Arizona withholding at the rate of (check only one box): 1.3% 1.8% 2.7% 3.6% 4.2% 5.1% of my gross taxable wages.
Additional amount to be withheld per paycheck \$ _____
- 3 I hereby elect an Arizona withholding percentage of zero, and I certify that I meet BOTH of the following qualifying conditions for this election:
 - I had NO Arizona tax liability for the prior taxable year, AND
 - I expect to have NO Arizona tax liability for the current taxable year.

I certify that I have made the percentage election marked above.

SIGNATURE	DATE
-----------	------

EMPLOYEE'S INSTRUCTIONS

Arizona Revised Statutes (ARS) §43-401 requires your employer to withhold Arizona income tax from your compensation paid for services performed in Arizona for application toward your Arizona income tax liability. Arizona withholding is a percentage of your gross taxable wages of every paycheck.

"Gross taxable wages" is the amount from each paycheck that will be included in box 1 of your federal Form W-2 at the end of the calendar year (i.e. gross wages net of pretax deductions, such as your portion of health insurance premiums). You may also have your employer withhold an additional amount from each paycheck.

Complete this form to elect an Arizona withholding percentage and any additional amount to be withheld from each paycheck. Give the completed form to your employer.

Current Employees

ALL EMPLOYEES ARE REQUIRED TO COMPLETE THIS FORM FOR WAGES PAID AFTER JUNE 30, 2010. Complete this form to elect an Arizona withholding percentage and designate an additional amount to be withheld. If you want to increase or decrease the amount of Arizona withholding in the future, you must complete this form again to change the Arizona withholding percentage or change the additional amount withheld.

New Employees

Complete this form within the first five days of employment to elect an Arizona withholding percentage. You may also have your employer withhold an

additional amount from each paycheck. If you do not complete this form, the department requires your employer to withhold 2.7% of your gross taxable wages until your employer receives a completed form from you.

Electing a Withholding Percentage of Zero

You may elect an Arizona withholding percentage of zero if you meet BOTH of the qualifying conditions for the election. You qualify for the election if: (1) you had no Arizona income tax liability for the prior taxable year, AND (2) you expect to have no Arizona income tax liability for the current taxable year.

Note that Arizona tax liability is gross tax liability less any tax credits, such as the family tax credit, school tax credits, welfare tax credits, or credits for taxes paid to other states. If you make this election, your employer will not withhold Arizona income tax from your wages for payroll periods beginning after the date of your election.

You should be aware that zero withholding does not relieve you from paying Arizona income taxes that might be due at the time you file your Arizona income tax return. Keep in mind that in order to elect zero withholding, you must meet BOTH conditions listed above. Therefore, if you have an Arizona tax liability when you file your return or if at any time during the current year conditions change so that you expect to have a tax liability, you should immediately complete a new Form A-4 and choose a withholding percentage that is applicable to your situation.

ADOR 81-8041 (6/10)



Attending Physician's Statement of Disability



The patient is responsible for the completion of this form without expense to Sedgwick CMS

PART ONE: TO BE COMPLETED BY EMPLOYEE PRIOR TO PROVIDING TO PHYSICIAN TO COMPLETE					
Employee Name (last name, first name, middle initial)					Social Security Number
Employee Street Address	Apt./Street No.	City	State	Zip Code	Country
Participating Employer					Telephone Number ()
					Date of Birth
<p>I certify all of the information above (except as corrected) is to the best of my knowledge true, correct and complete. I hereby authorize the use or disclosure of my personal health information upon request by Sedgwick CMS, Inc. from the following authorized persons or organizations: Pacific Care, Inc., and Cigna, Inc. I hereby further authorize the above persons or organizations, any physician, medical practitioner, hospital, clinic, other medical or medically related facility, pharmacy, insurer, claims administrator, and my employer(s) to disclose or furnish to Sedgwick CMS, my employer, or any of their authorized representatives, all facts concerning my medical condition and disability (including physical, mental health, alcohol, substance abuse and HIV related information), wages or earnings, that are within their knowledge and to allow inspection of and provide copies of any medical records (including diagnosis, prognosis, prescriptions or medication, psychiatric, drug or alcohol abuse treatment). I understand that this information will be used to determine my eligibility for benefits or compensation to which I may be entitled under any benefit plan or practice of my employer, which requires evaluation for physical or mental condition, including, but not limited to, a leave from work for medical reasons. I further authorize disclosure of my personal health information to others by Sedgwick CMS, my employer, or any of their authorized representatives, in order to determine my eligibility for, process, evaluate and administer all claims for benefits or compensation for which I may be entitled. I acknowledge my right to make a copy of this authorization. I understand this authorization is valid for the duration of my claim for disability benefits or twenty-four months, whichever is earlier. A photocopy of this authorization is as valid as the original. I may revoke this authorization at any time before its expiration date by notifying Sedgwick CMS, Inc. in writing, but the revocation will not have any effect on any actions the party took before it received the revocation. I understand that my personal health information may be released to others in accordance with the terms of this release.</p> <p>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.</p>					
Employee's Signature _____			Date Signed _____		
Name of Personal Representative who has Authority to Sign on Behalf of the Employee _____			Signature of Personal Representative who has Authority to Sign on Behalf of the Employee _____		

PART TWO: TO BE COMPLETED BY PHYSICIAN (Please print or type and sign and initial where indicated.)	
History	Patient's symptoms result from (Check all that apply): <input type="checkbox"/> Employment <input type="checkbox"/> Illness <input type="checkbox"/> Auto Accident (state in which accident occurred) _____ <input type="checkbox"/> Other accident _____ <input type="checkbox"/> Pregnancy (expected/actual delivery date) _____ / _____ / _____ Type of delivery _____ Date symptoms first appeared _____ / _____ / _____ Patient's height _____ Weight _____ First visit of this condition _____ / _____ / _____ Last visit _____ / _____ / _____ Most recent comp exam _____ / _____ / _____ Did you recommend patient stop working? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", when _____ / _____ / _____ Name(s) and address(es) of other treating or referring physician(s) _____
	Hospital Name _____ Confinement dates _____ / _____ / _____ through _____ / _____ / _____
Diagnosis	Diagnoses (including complications) _____ ICD-9 code primary condition _____ Subjective symptoms _____ ICD-9 code secondary condition _____ Objective findings (including results/copies of x-rays, lab tests, EKGs, MRIs and scans) _____
	Describe treatment program and give dates of any surgery, medications, physical therapy or psychotherapy. Medications (Provide dosage and frequency) _____ Surgery Date/Type _____
Prognosis	1. Patient is expected to return to work: _____ / _____ / _____ Full-time _____ / _____ / _____ Part-time _____ 2. Has patient reached maximum medical improvement? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No", when _____ / _____ / _____ <input type="checkbox"/> Unknown 3. What limitations prevent the patient from returning to employment? 4. Would job modification enable patient to work with impairments? <input type="checkbox"/> Yes <input type="checkbox"/> No

This is a two page form – Initial and date here and continue to next page:
 Physician Initials _____ Date _____
 Sedgwick CMS, Inc. / P.O. Box 9830 / Calabasas, CA 91372-0830 / Phone (800) 495-9301 / Fax (818) 591-7664

Attending Physician's Statement of Disability (Page 2 of 2) Patient's Name _____

Cardiac	Functional Capacity (American Heart Association) (Complete only if applicable.) <input type="checkbox"/> Class 1 (No limitation) <input type="checkbox"/> Class 2 (Slight limitation) <input type="checkbox"/> Class 3 (Marked limitation) <input type="checkbox"/> Class 4 (Complete limitation) Blood pressure (latest reading) _____ / _____ As of (date) _____ / _____ / _____ Is patient in a cardiac rehabilitation program? <input type="checkbox"/> Yes <input type="checkbox"/> No																																								
Physical Limitations	Functional Capabilities: (Complete only if applicable.) 1. In terms of an 8-hour workday, patient can (Circle full capacity for each activity) A. Sit Number of hours 1 2 3 4 5 6 7 8 B. Stand Number of hours 1 2 3 4 5 6 7 8 C. Walk Number of hours 1 2 3 4 5 6 7 8 2. In terms of an 8-hour workday <table border="1" style="width:100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr> <th style="width:35%;">On the job, patient can</th> <th style="width:15%;">Not at all</th> <th style="width:15%;">Occasionally (½ to 2 ½ hours)</th> <th style="width:15%;">Frequently (2 ½ to 5 ½)</th> <th style="width:20%;">Continuously (5 ½ to 8 hours)</th> </tr> </thead> <tbody> <tr> <td>A. Bend/ Stoop</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>B. Climb</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>C. Push/Pull</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>D. Lift/Carry</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td> 1. Up to 10 pounds</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td> 2. 11-20 pounds</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td> 3. 21-50 pounds</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> </tbody> </table>	On the job, patient can	Not at all	Occasionally (½ to 2 ½ hours)	Frequently (2 ½ to 5 ½)	Continuously (5 ½ to 8 hours)	A. Bend/ Stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	B. Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C. Push/Pull	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D. Lift/Carry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Up to 10 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. 11-20 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. 21-50 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Mental Impairment	Do you believe a legal guardian or conservator should be appointed for this patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Check appropriate response: (Complete only if applicable.) Judgment <input type="checkbox"/> No deficits noted <input type="checkbox"/> Mildly impaired <input type="checkbox"/> Moderately <input type="checkbox"/> Severely <input type="checkbox"/> Obvious impairment Memory, short-term <input type="checkbox"/> No deficits noted <input type="checkbox"/> Mildly impaired <input type="checkbox"/> Moderately <input type="checkbox"/> Severely <input type="checkbox"/> Obvious impairment Memory, long term <input type="checkbox"/> No deficits noted <input type="checkbox"/> Mildly impaired <input type="checkbox"/> Moderately <input type="checkbox"/> Severely <input type="checkbox"/> Obvious impairment Concentration <input type="checkbox"/> No deficits noted <input type="checkbox"/> Mildly impaired <input type="checkbox"/> Moderately <input type="checkbox"/> Severely <input type="checkbox"/> Obvious impairment Affect <input type="checkbox"/> Normal range <input type="checkbox"/> Constricted Mood <input type="checkbox"/> Neutral <input type="checkbox"/> Cheerful <input type="checkbox"/> Depressed <input type="checkbox"/> Manic Psychosis <input type="checkbox"/> No symptoms noted <input type="checkbox"/> Delusions <input type="checkbox"/> Thought disorder <input type="checkbox"/> Bizarre ideas <input type="checkbox"/> Hallucinations Sleep <input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> No change Appetite <input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> No change Energy <input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> No change																																								
Work Capabilities	Please describe fully how patient's symptoms/limitations affect ability to work, e.g., how are work schedule or duties restricted and why? 																																								
Remarks	 																																								
Name	Physician's Name _____ Degree/Specialty _____ Street Address _____ Telephone Number (____) _____ City _____ State _____ Zip code _____ Fax Number (____) _____ Physician's Signature _____ Date _____ / _____ / _____ DO NOT PREDATE PHYSICIAN'S LICENSE NUMBER _____																																								

SEDGWICK CMS, Inc. / P.O. Box 9830 / Calabasas, CA 91372-0830 / Phone (800) 495-9301 / Fax (818) 591-7664