Tompkins County Department of Human Resources
125 East Court Street, Ithaca, NY 14850 | P: (607) 274-5526 | F: (607) 274-5401 | www.TompkinsCountyNY.gov
Inclusion through Diversity

Claim for Benefits

To Be Completed by Physician ONLY (print clearly)

Tompkins County is eager to work with employees and their physicians to facilitate a return to full-time or part-time work, with or without reasonable accommodation. Your participation in this process is critical and welcome. Your recommendations for a successful and speedy return-to-work will be greatly appreciated. Submit this completed form directly to Human Resources via contact information above. Thank you.

This patient has authorized the release of medical information regarding the following disability claim.

****This form must be submitted prior to an employee being approved to return to work. Substitute forms may not be accepted.****

Employee's Full Name:	**Date Employee Out of Work Start Date:**
Physician's Name and field of specialization:	
My diagnosis for the employee is:	
I last examined or treated the employee for that condition on date:	
I expect this condition to continue until date:	

☐ In my opinion, the employee may return to work **without** restriction on **date**: _____

☐ In my opinion, the employee may return to work **with** the restrictions described below on **date**:_____

Restrictions

The employee has the following restrictions (indicate all restrictions on the employee's work activities, including but not limited to, hours of work, specific job duties the employee may perform on a limited basis, repetitive motion restrictions, and specific job duties the employee may not perform at all):

☐ These limitations/restrictions are limited and will continue until (indicate the date each restriction listed in the preceding answer will end):

☐ These limitations/restrictions are permanent.

I will next examine the employee on date:	

My signature indicates that I have read and understand the employee's job description and the limited tasks within the job description and that my findings are based on my medical assessment of this employee's ability to perform the job duties.

Physician Signature	**Date:**

Need more help? Call (607) 274-5530