PEBA℠
SC Retirement Systems and State Health Plan

Standard Insurance Company

Benefits Department
PO Box 2800 Portland OR 97208 855.977.7764 Tel

Reset

Stay at Work Medical Information Request

Employee, complete this section.

Employee name_____ Date of birth_____

Employer_____

Provider: The purpose of this form is to help us provide the correct accommodations that will allow your patient to successfully remain at work. We need to understand your patient's limitations and restrictions in order to provide assistance. *Please include results of diagnostic testing and pertinent chart notes*.

1. Diagnosis (include the ICD code)_____

   Date of most recent visit_____ Frequency of visits_____

   Expected duration of impairment from this condition_____

2. Describe your patient's current symptoms._____

3. What are your patient's work limitations and restrictions?_____

4. Planned course of treatment (include expected duration):_____

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false, or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

Physician's signature		Date	
Physician's name (please print)		Specialty	
Address	City	State	ZIP
Phone no.	Fax no.		

Please fax completed form to The Standard at 971.321.5727 or 855.207.6115.

Print