

**STATE OF NEW JERSEY – DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
DIVISION OF TEMPORARY DISABILITY INSURANCE**

PART A | **INFORMATION TO BE COMPLETED BY THE CLAIMANT – Print or Type** WDS-1(R-2-08)

1. Name: Last	First	Middle	2. Birth Date	3. Social Security Number
---------------	-------	--------	---------------	---------------------------

4. Home Address – required (Street, Apt #, City, State, Zip Code)	5. County
--	-----------

6. Mailing Address – if different (Street, Apt #, City State, Zip Code)	7. Male <input type="checkbox"/> Female <input type="checkbox"/>	8. Occupation
---	---	---------------

9. Are you a citizen of the United States? Yes <input type="checkbox"/> No <input type="checkbox"/>	10. Alien Reg. No.	11. Work Authorization
If NO , answer #10 & 11 and give country of origin: _____		From _____ To _____

12a. What was the last day that you actually worked before your disability began?	Month	Day	Year
12b. Reason for separation: <input type="checkbox"/> Illness/Accident/Maternity <input type="checkbox"/> Terminated <input type="checkbox"/> Quit			
13. What was the first day you were unable to work due to present disability: (Include Saturday, Sunday, or Holiday) Do not list future dates			
14. If you have recovered or returned to work from this disability, list date: (Do not use dates in the future)			

15. Date(s) of emergency room care: _____ or hospitalization: From _____ To _____
Month/Day/Year Month/Day/Year Month/Day/Year

16. Describe your disability (How, when, where it happened) _____

17. Was this injury/illness caused by your job? Yes or No (This question must be answered.)
 If Yes, date of work related injury/illness: _____
 Was your employer notified that your injury was caused by your job? Yes or No

18. Identify the physician or hospital treating you for this disability: Name: _____
 Address: _____ Telephone: (____) _____

Employment Information – Beginning with your last employer, list all employment (both full and part-time) in the past 18 months. If you had more than 2 employers, list the remaining employers on the reverse side of this form in the space provided.

19a. Name and address of your most recent employer: _____ _____ <small>(Street) (City) (State) (Zip)</small>	Period of employment: From _____ To _____ <small>month/day/year month/day/year</small> Work Location _____ Telephone: _____ <small>City State</small>
Occupation: _____ Full time <input type="checkbox"/> Part time <input type="checkbox"/> Union _____ Division _____	
Check the days of the week you normally work. SUN <input type="checkbox"/> MON <input type="checkbox"/> TUE <input type="checkbox"/> WED <input type="checkbox"/> THUR <input type="checkbox"/> FRI <input type="checkbox"/> SAT <input type="checkbox"/>	

19b. Name and address: _____ _____ <small>(Street) (City) (State) (Zip)</small>	Period of employment: From _____ To _____ <small>month/day/year month/day/year</small> Work Location _____ Telephone: _____ <small>City State</small>
Occupation: _____ Full time <input type="checkbox"/> Part time <input type="checkbox"/> Union _____ Division _____	
Check the days of the week you normally work. SUN <input type="checkbox"/> MON <input type="checkbox"/> TUE <input type="checkbox"/> WED <input type="checkbox"/> THUR <input type="checkbox"/> FRI <input type="checkbox"/> SAT <input type="checkbox"/>	

20. **Other Benefits – You Must Answer Each Question Listed Below For the Period of Disability Covered By This Claim:**

a. Have you worked after your disability began? (Including self-employment) Yes No

b. Have you been receiving sick or vacation pay? Yes No

c. Have you been involved in a labor dispute? Yes No

21. **Since your last day of work have you received, claimed or applied for:**

a. Federal Social Security Disability Benefits? Yes No

b. Pension benefits from your most recent employer? Yes No

c. Temporary Disability Benefits from another State? Yes No

d. Any other disability benefits provided by your employer or union? Yes No

e. Unemployment Insurance Benefits? Yes No

BE SURE TO COMPLETE AND SIGN PART A1



Claimant's Name: _____

Social Security Number

Claimant's Telephone No: (____) _____

| |

PART A1**CLAIMANT'S AUTHORIZATION AND CERTIFICATION STATEMENTS**

MUST BE COMPLETED AND SIGNED BY THE CLAIMANT

1. Please designate a representative to obtain claim information for you if you cannot call this Agency yourself. The Law only permits claim information to be given to you or your representative.

Representative Name: _____ Birth Date: _____

Phone (____) _____

2. **Certification and Signature** I was unable to work during the period for which benefits are claimed and hereby certify that I have read and understand my benefit rights and responsibilities. I am aware that if any of the foregoing statements made by me are known to be false, or I knowingly fail to disclose a material fact, I may be subject to penalties, which may include criminal prosecution. You are hereby authorized to verify my Social Security Account Number, and obtain any medical, employment and Social Security benefit entitlement information that is necessary to determine my eligibility for benefits.

Sign Here _____ Date _____

Witness signature if claimant writes an "X" _____

Phone No. (____) _____ E-Mail Address _____

Note: The NJ Temporary Disability Benefits Program is not a "covered entity" under the Federal Health Information Portability & Accountability Act (HIPAA). All medical records of the Division, except to the extent necessary for the proper administration of the Temporary Disability Benefits Law are confidential & are not open to public inspection. The Division protects all records that may reveal the identity of the claimant, or the nature or cause of the disability and the records may only be used in proceedings arising under the Law.

USE THIS SPACE TO LIST ADDITIONAL EMPLOYERS FOR QUESTION 19.

Name and address: _____ _____ (Street) (City) (State) (Zip)	Period of employment: From _____ To _____ month/day/year month/day/year Work Telephone: _____ Location _____ City State
Occupation: _____ Full time <input type="checkbox"/> Part time <input type="checkbox"/> Union _____ Division _____	

Check the days of the week you normally work. SUN MON TUE WED THUR FRI SAT

Name and address: _____ _____ (Street) (City) (State) (Zip)	Period of employment: From _____ To _____ month/day/year month/day/year Work Telephone: _____ Location _____ City State
Occupation: _____ Full time <input type="checkbox"/> Part time <input type="checkbox"/> Union _____ Division _____	

Check the days of the week you normally work. SUN MON TUE WED THUR FRI SAT **USE THIS SPACE TO PROVIDE ANY ADDITIONAL INFORMATION FOR QUESTIONS ON PART A**

If more space is needed, attach an additional sheet of paper. Be sure your Social Security Number appears on all pages.

Claimant's Name: _____

Social Security Number

Claimant's Address: _____

| |

Claimant's Telephone No: (____) _____

PART B

**MEDICAL CERTIFICATE
(TO BE COMPLETED BY YOUR DOCTOR AFTER YOU BECOME DISABLED)**


1a. Patient has been under my care for this period of disability: **FROM** _____ **TO** _____
(Month/Day/Year) (Month/Day/Year)

b. Frequency of treatment: _____

c. Patient was last treated by me on:  _____
Month Day Year

2. Enter the date the patient was unable to perform his/her regular work due to this disability: _____
Month Day Year

3. Estimated Recovery: (Give the approximate date patient will be able to return to work.) _____
Month Day Year

4. If now recovered, on what date was the patient first able to work?  _____
Month Day Year

5. Diagnosis: (nature and cause of this disability which prevents patient from working) _____
_____ **ICD Code:** _____

Clinical data and tests to support diagnosis: _____

6a. If pregnancy, provide estimated date of delivery:  _____
Month Day Year

b. Complications, if any. _____

c. If pregnancy terminated, enter the date:  _____
Month Day Year

And identify the reason: Birth C-Section Miscarriage Abortion

7a. Date(s) of emergency room care or hospitalization: FROM _____ TO _____

b. Name and address of any specialist treating patient: _____

8. Type of surgery: _____ Date of Surgery _____ Anticipated Surgery Date _____

Is surgery for cosmetic purposes only? Yes No

9. In your opinion, was this disability: Due to an accident at work? Not related to his/her work
 Due to a condition which developed because of the nature of the work.

10. Was this patient referred to you? Yes No If yes, please supply the information below if available.

Name of referring doctor _____ Referring doctor's telephone #: _____

11. I certify that the above statements, in my opinion, truly describe the patient's disability and the estimated duration thereof:

(Print Doctor's Name and Medical Degree)

(Original Signature of Doctor Required)

(Date Signed)

(Address)

(Certificate License No. and State)

If Resident, check

(Address)

(Specialty of Treating Physician)

(City) (State) (Zip Code)

Telephone Number: () _____ FAX Number: () _____

