DS-1C (1/18)

Claimant's Name ______________________________

Claimant's Address ______________________________

Claimant's Date of Birth ______________________________

Social Security Number

__ __ __-__ __-__ __ __ __

PART B

MEDICAL CERTIFICATE – Have your healthcare provider complete Part B.

N.J.S.A 12:18-1.6 prohibits charging a fee to complete this form.

1 Patient has been under my care for this disability **FROM** ____|____|____ **TO** ____|____|____ ________
first date of treatment / most recent treatment / frequency

2 Date the patient was unable to perform regular work due to this disability ____|____|____
(Doctor's signature date must be on or after this date unless this is a pregnancy claim)
Month / Day / Year

3 Estimated recovery date (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 (what is the disabling condition)______________________________

______________________________ **ICD Code**______________________________

6 Do you believe this patient is mentally capable of handling their own affairs, including the use of benefits? ☐ Yes ☐ No

7a If pregnancy, provide estimated date of delivery: ____|____|____
Month / Day / Year

b Complications, if any pre-term______________postpartum______________

c If pregnancy terminated, enter the date: ____|____|____
Month / Day / Year

And identify the reason: ☐ Birth ☐ C-Section ☐ Miscarriage ☐ Abortion

8 Date(s) of emergency room care or hospitalization: from ____|____|____ to ____|____|____
Month Day Year / Month Day Year

9 Type of surgery ______________ Date of Surgery ____|____|____ Anticipated Surgery Date ____|____|____
Month Day Year / Month Day Year

Is surgery for cosmetic purposes only? ☐ Yes ☐ No

10 Was this disability ☐ Due to an accident at work ☐ Due to the nature of the work ☐ Not related to their work

11a Was this patient referred to you? ☐ Yes ☐ No If Yes, name of referring doctor ______________

Referring doctor's phone (   ) ______________ **11b** Name of any specialist treating the patient ______________

12 I certify that the above statements describe the patient's disability and the estimated duration thereof

______________________________ ______________ ______________
Print Doctor's Name / License No. and State* / Specialty

______________________________ Phone (   ) ______________
Street Address

______________________________ Fax (   ) ______________
City / State / ZIP Code

______________________________ ____|____|____ ☐ Check, if Resident.
Signature of Doctor / **Date Signed**

The date signed must be on or after the date in Question 2, unless this is a pregnancy claim.

***If completed by a Physician's Assistant (PA-C), provide the license number of the supervising doctor.**

WDS-1 (1/18)

Claimant's Name ______________________________ Phone (   )__________________

Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Claimant's Address ____

PART C

EMPLOYER STATEMENT – Have your employer or company representative complete Part C.

1 EMPLOYER STATUS

Your Federal Employer Identification Number (FEIN) ______________________

2 WORK LOCATION

Provide the location that the employee physically reports to work

City________________________________ State_____________

3 CHECK DAYS OF THE WEEK that the employee normally works

☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Varies

4 LAST ACTUAL DAY WORKED before this disability

(Do not use a payroll week ending date) ______|______|______
Month Day Year

a Reason for separation from work ____

b Is separation ☐ Temporary? ☐ Permanent?

c Has claimant returned to work? ☐ Yes ☐ No

If Yes, give date ______|______|______

d If the work was intermittent, list dates ________________________________

5 CONTINUED PAY

a Have you paid or do you expect to pay the claimant for any period after the last day of work? ☐ Yes ☐ No

b If yes, give dates from: _____|_____|_____ to: _____|_____|_____
Month Day Year Month Day Year

c Amount per week $____________ (if amount varies please attach a list of dates/amounts)

d Total amount paid for entire given period $______________

e Check the number that best describes the monies paid in item c.

☐ 1. Paid time off (vacation, sick, personal, etc.)

☐ 2. Difference between regular wkly wages and disability benefits to be received

☐ 3. Supplemental benefits (unallocated payout will have no impact)

☐ 4. Severance pay With notice ☐ In lieu of notice ☐

☐ 5. Pension (attach pension approval letter)

Note: Items 1, 4, and 5 may reduce benefits to the claimant.

6 GOVERNMENT EMPLOYERS

a Payroll Number (For N.J. state employees) ____________________

b If claimant has applied for or received donated leave, attach dates and amounts.

7 WORKERS' COMPENSATION LIABILITY

a Did the claimant's disability happen in connection with their work or while on your premises, or was the disability due in any way to their occupation? ☐ Yes ☐ No

b If Yes, have you filed or do you intend to file a Workers' Compensation claim on behalf of this claimant? ☐ Yes ☐ No

c If Yes, list Workers' Compensation Insurance carrier below:

Name________________________ Phone (   ) _____________________

Address____

Policy #_______________________ Claim #_________________________

8 BASE WEEKS / BASE YEAR WAGES

A base week is a calendar week in which the N.J. employee had gross earnings of **$169** or more.

a Total number of **Base Weeks** __________

b Total **Gross Wages** in Base Year $ __________
(52 weeks prior to first day of disability)

9 Weekly Wage (base hrs x rate) $__________

Hourly Rate $______/hr

10 Weekly Wages

Provide claimant's GROSS earnings in New Jersey employment and period ending dates.

Note: If the weeks listed below include overtime, bonuses, etc., attach an explanation and separate the regular wages earned. **Payroll records will not be accepted in place of completing this statement.**

Description of Calendar Week	Week Ending Date	Gross Wages
Week Disability Began	/ /	$
Week before Disability	/ /	$
2nd Week Before Disability	/ /	$
3rd Week Before Disability	/ /	$
4th Week Before Disability	/ /	$
5th Week Before Disability	/ /	$
6th Week Before Disability	/ /	$
7th Week Before Disability	/ /	$
8th Week Before Disability	/ /	$
9th Week Before Disability	/ /	$
10th Week Before Disability	/ /	$
TOTAL GROSS WAGES FOR ABOVE WEEKS		$

Are you exempt from FICA tax? ☐ Yes ☐ No

I CERTIFY THE INFORMATION GIVEN ABOVE IS CORRECT

Firm Name ______________________________ Phone (   ) ____________

Address __________________________________ Fax (   ) ____________

City _________________________ State _________ ZIP Code _____________

Name/Title____

Signature____________________________

Do not sign/date before the last day worked

Date (required) ________|_________|_________

DS-1C (1/18)

Claimant's Name ______________________________

Claimant's Address ______________________________

Social Security Number

__ __ __- __ __- __ __ __ __

Part C-1

CLAIMANT CERTIFICATION OF WAGES & EMPLOYMENT – If any of your employers in the last six (6) months refuse to complete Part C, or if you are unable to reach them, you are required to use this form to provide proof of wages & employment in place of Part C. You must also attach proof of wages (paystubs, W-2 forms, tip records, etc.).

1 EMPLOYER NAME______________________________

2 EMPLOYER STATUS
Federal Employer Identification Number (FEIN)____________________

3 EMPLOYER ADDRESS______________________________ ____________ ______ ______
Street City State Zip

4 EMPLOYER PHONE (______) __________________ (HR Office, if available)

5 LAST DAY WORKED
My last physical day worked was _____|_____|_____
Month Day Year

6 WORK LOCATION
Provide the location that you physically reported to:
City ______________________ State ____________

7 BASE YEAR
During the 52 calendar weeks prior to my first day of being disabled I worked _______weeks (with earnings of $169 per week or more) with this employer. My gross earnings, before deductions, during that time were: $__________________

8 WEEKLY WAGES In the eight (8) weeks prior to my disability or family leave I earned the following with this employer:

Calendar Week-ending	Gross Wages	Calendar Week-ending	Gross Wages
1. ____/____/____	$________________	5. ____/____/____	$________________
2. ____/____/____	$________________	6. ____/____/____	$________________
3. ____/____/____	$________________	7. ____/____/____	$________________
4. ____/____/____	$________________	8. ____/____/____	$________________

9 CONTINUED PAY
Have you been paid or do you expect to be paid for any period after the last day of work? ☐ Yes ☐ No
If yes:
Dates paid: from: _____|_____|_____ to: _____|_____|_____ Amount per week $___________ Total amount paid $______________
Month Day Year Month Day Year

Check the number that best describes the monies paid in item c.
- ☐ 1. Paid time off (vacation, sick, personal, etc.)
- ☐ 2. Difference between regular weekly wages and disability benefits to be received
- ☐ 3. Other pay from your employer (explain): ______________________________
- ☐ 4. Severance pay With notice ☐ In lieu of notice ☐
- ☐ 5. Pension (attach pension approval letter)

Note: Items 1, 4, and 5 may reduce your benefits.

10 CERTIFICATION AND SIGNATURE
My signature on this form indicates that the statements made by me are true and correct to the best of my knowledge. I make this statement with knowledge that the wages and employment information set forth herein will be used as a basis for determining the temporary disability/family leave benefits to which I may be entitled and that any willful misrepresentation or false statement made for the purpose of obtaining or increasing benefits will render me liable to penalties provided by Temporary Disability Benefits Law (N.J.S.A. 43:21-55).

Date_______________ Claimant's Signature______________________________ Phone (_____) _______________