Concordia-Health
Official Legal Address
1901 Pennsylvania Avenue NW
Washington, DC 20006
United States
www.concordia-health.org

Membership Number: _____

Member ID: _____

Case Reference: _____

REQUEST FOR AUTHORIZATION TO RESUME PART-TIME WORK DURING A PERIOD OF WORK INCAPACITY

Important – Please Read Carefully

What is this form used for?

You must complete this form if you wish to resume work on a part-time basis while you are recognized as being unable to work.

This includes:

- Resuming the self-employed activity you performed before your work incapacity;
- Starting a new self-employed activity;
- Returning to work as an employee;
- Engaging in any other paid or unpaid activity that is compatible with your medical condition.

Where should you submit this form?

Please complete this form and submit it to Concordia Health using your preferred submission method or through one of our service offices.

When should you submit this form?

You must submit this form **no later than the first business day before your planned return to work**.

Failure to notify Concordia Health within the required timeframe may result in a **10% reduction of**

your disability benefits or the denial of benefits, in accordance with the program rules governing the coordination of disability benefits with income earned from authorized work activities.

Important

This form constitutes a **request for authorization**. Before resuming any part-time work, you should obtain written approval from the **Medical Advisor**.

Exception

If, after your work incapacity begins, you continue an activity in the sports or community services sector under a contract that was signed and actively performed before your work incapacity started, you may continue that activity before receiving the Medical Advisor's decision.

In this situation, you must submit this form **within one month** after your work incapacity has been declared.

Documents to Attach

If you are returning to work as an employee, please attach a copy of your employment contract.

If your employment contract is not yet available, please submit it to Concordia Health as soon as it becomes available.

If you need assistance completing this form, please contact Concordia Health.

Section 1 – Member Identification

I, the undersigned,

First Name: _____

Last Name: _____

Address: _____

Member ID: _____

Email: _____

Mobile or Phone Number: _____

hereby request authorization from the **Medical Advisor** to resume part-time work during my period of work incapacity, effective:

Date (MM/DD/YYYY): ____ / ____ / _____

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1. Type of Activity

Please select the activity that applies to you.

☐ **Self-Employed Member**

- ☐ Resuming the self-employed activity performed before the beginning of my work incapacity.
- ☐ Starting a new self-employed activity.

☐ **Employee**

- ☐ Hourly employee
- ☐ Salaried employee

☐ **Sports or Community Services Activity**

- ☐ Continuing an activity under an existing agreement that was established and actively performed before my work incapacity began.
- ☐ Beginning an activity that was not previously performed before my work incapacity.

☐ **Other Activity**

- ☐ Paid activity
- ☐ Unpaid activity

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2. Description of the Activity

Please describe, as clearly and specifically as possible, all duties and responsibilities that you will perform.

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3. Work Schedule

Please indicate the days and hours during which you will be working.

☐ **Variable Work Schedule**

I work according to a **variable work schedule** (no fixed working hours).

Number of hours per week: _____

☐ **Fixed Work Schedule**

I work according to a **fixed work schedule**. If your working days and hours are the same each week, please complete **Week 1 only**.

Number of hours per week: _____

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Week 1	From ____ To ____	From ____ To ____	From ____ To ____	From ____ To ____	From ____ To ____	From ____ To ____	From ____ To ____
	From ____ To ____	From ____ To ____	From ____ To ____	From ____ To ____	From ____ To ____	From ____ To ____	From ____ To ____
Week 2	From ____ To ____	From ____ To ____	From ____ To ____	From ____ To ____	From ____ To ____	From ____ To ____	From ____ To ____
	From ____ To ____	From ____ To ____	From ____ To ____	From ____ To ____	From ____ To ____	From ____ To ____	From ____ To ____
Week 3	From ____ To ____	From ____ To ____	From ____ To ____	From ____ To ____	From ____ To ____	From ____ To ____	From ____ To ____
	From ____ To ____	From ____ To ____	From ____ To ____	From ____ To ____	From ____ To ____	From ____ To ____	From ____ To ____
Week 3	From ____ To ____	From ____ To ____	From ____ To ____	From ____ To ____	From ____ To ____	From ____ To ____	From ____ To ____
	From ____ To ____	From ____ To ____	From ____ To ____	From ____ To ____	From ____ To ____	From ____ To ____	From ____ To ____

Additional Information

Please provide any additional information that may help us understand your work schedule.

4. Additional Information

Employer or Organization *(Complete this section only if your activity is performed as an employee.)*

Name:

Address:

Phone Number:

Employer Identification Number (EIN):

> **Important:** If applicable, the Employer Identification Number (EIN) must be provided to allow your request to be processed.

If available, please also provide:

Primary Care Provider

Name:

Address:

Phone Number:

Occupational Health Provider *(if applicable)*

Name:

Address:

Phone Number:

Declaration

I certify that the information provided in this application is true, accurate, and complete.

I understand that providing false or misleading information may affect my eligibility for benefits under the Concordia Health Mutual Aid Program.

Date: ____ / ____ / _____

Signature: _____

Privacy Notice

Concordia Health processes your personal information in accordance with applicable privacy and data protection laws.

You have the right to access, update, correct, or request the deletion of your personal information, as permitted by applicable law.

For more information about how Concordia Health collects, uses, and protects your personal information, please refer to our **Privacy Policy**, available on our website.

End of Form – CH-PTR-002 (v1.0)