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

Member ID
SSN (optional, if applicable):
Date of Birth:
Subject:

DECLARATION AND REQUEST FOR AUTHORIZATION TO ENGAGE IN OR CONTINUE AN ACTIVITY DURING A PERIOD OF WORK INCAPACITY

Important – Please read this information before completing the form.

What is the purpose of this form?

You must complete this form if:

- you are returning to part of the work you performed before your work incapacity began;
- you are resuming a different job as an employee;
- you are resuming an activity as a self-employed individual that is compatible with your medical condition;
- you are engaging in any paid or unpaid activity that is compatible with your medical condition;
- you wish to renew your current authorization.

Where should you submit this form?

This form consists of two sections: an administrative section and a medical section.

Please complete both sections and submit the form to the **Concordia Health Medical Advisor**.

When should you submit this form?

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

If you are requesting a renewal of an existing authorization, your request must be received before

your current authorization expires.

Important

A late request to resume part-time work or to renew your authorization may result in a **10% reduction of your disability benefits** or even **denial of benefits**, in accordance with the Mutual Aid Program's rules regarding the receipt of disability benefits while performing an authorized activity.

Please note

This form serves as a request for authorization, or for the renewal of an existing authorization, to engage in or continue an activity during a period of work incapacity.

Before beginning any part-time activity during your period of work incapacity, you are strongly encouraged to obtain written authorization from the **Concordia Health Medical Advisor**, even if you are renewing an activity that was previously approved.

Exception

If you continue an activity that began before your work incapacity and that remains compatible with your medical condition, you must notify **Concordia Health** within **30 days** after your work incapacity has been reported.

Documents to attach

If your employment agreement has been amended, modified, or replaced, please attach a copy of the current agreement to this form.

If the updated agreement is not yet available, please submit it as soon as it becomes available.

If applicable, you are encouraged to include any documentation supporting your ability to safely resume work.

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

Section 1: Declaration and Request for Part-Time Work During a Period of Disability

I, the undersigned,

First Name: _____

Last Name: _____

Member ID Number: _____

Mobile or Phone Number: _____

Email Address: _____

☐ I declare that I have resumed, or will resume, the following activity effective ____ /____ /_____:

☐ I request the renewal of my current authorization effective ____ /____ /_____ for the following activity:

Based on the request below, I respectfully request authorization from the **Concordia Health Medical Advisor** to engage in this activity or to renew my current authorization.

In both cases, Section 2 must be completed in full.

I certify that the information provided in this form is true, complete, and accurate to the best of my knowledge. I understand that providing false, misleading, or incomplete information may result in the denial, suspension, or recovery of program benefits and may lead to additional administrative action.

Important

During the first year of your disability, you must continue to submit updated medical certifications within **7 calendar days** whenever your period of disability is extended, even if you have been authorized to work part-time by the **Concordia Health Medical Advisor**.

Date: ____ /____ /_____

Signature: _____

Section 2: Request for Authorization or Renewal of Part-Time Work During a Period of Disability

I, the undersigned,

First Name: _____

Last Name: _____

hereby request authorization from the **Concordia Health Medical Advisor** to begin or continue the following work activity effective ____ /____ /_____.

Description of the activity:

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1. Please indicate the type of work activity by checking the appropriate box.

☐ Employee

- ☐ Returning to the same employer*
- ☐ Working for a different employer

☐ Self-employed

☐ Independent contractor

☐ Childcare provider

☐ Volunteer

☐ Other (please specify): _____

If your activity is based on an existing work agreement, please indicate:

- ☐ This activity continues under an agreement that was already in effect before my period of disability began.
- ☐ This is a new activity or work agreement that began after my disability started.

*** If you are returning to the same employer, please indicate the number of hours you worked per week before your disability began (for example, 40, 32, or another schedule):**

_____ hours per week

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2. Please describe the duties you will perform.

Please describe your work activities as accurately and completely as possible.

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3. Please specify your working schedule

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

Number of hours per week under the medical part-time arrangement:

☐ I work according to a fixed schedule. My weekly work schedule is provided below.

If your working days and hours are the same each week, please complete **Week 1 only**.

Number of hours per week under the medical part-time arrangement:

What is the total number of hours considered full-time within your organization?
(Your employer can provide this information.)*

* Required

Weekly schedule

Day	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 4	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 relevant information regarding your work schedule:

4. Please complete the information below

Name of employer or organization *(to be completed only if you are not self-employed)*

Address

Phone number

Tax / Identification number

☐ Employer Identification Number (EIN): _____

☐ Social Security Number (SSN): _____

Important

If the required identification number is not provided, the request cannot be processed.

Additional information (if applicable)

If available, please include:

Primary care provider contact information
(Name, address, phone number)

Workplace health or occupational health contact information (if applicable)
(Name, organization, phone number)

Declaration

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

Date: ____ /____ /_____

Signature: _____

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

You have the right to:

- access your personal data
- request correction or completion of your data
- object to certain types of processing
- request restriction of processing
- request deletion of your data, where applicable

For more information about how your data is processed, please refer to our **Data Protection Policy** available at the following address:

https://www.concordia-health.org/terms-of-use