Please type or print clearly in ink

Georgia Department of Community Health
State Health Benefit Plan

Disability Certification

P.O. Box 1990
Atlanta, Georgia 30301

I. Employee Identification.

Social Security Number ☐☐☐ – ☐☐ – ☐☐☐☐

Last Name | First | Initial

Apartment/Box/Route

Street Address

City, State | Zip Code (5-digit + 4-digit)

County of Residence | Daytime Telephone Number ( )

II. Patient Identification.

Does this certification relate to the employee? ☐ Yes ☐ No

OR

Does this certification relate to a seriously ill family member? ☐ Yes ☐ No

If the certification relates to a seriously ill family member, provide the following information:

Last Name | First | Initial

Relationship to Employee

Date of Birth		
Month	Day	Year

III. Physician Statement.

Complete for the patient in Section II

- If the patient is the employee, will the patient be able to perform normal job duties during the period of disability? Yes ☐ No ☐
- If the patient is not the employee, is the employee's presence necessary or beneficial to the care of the patient? Yes ☐ No ☐
- If the disability is due to pregnancy, please give expected date of delivery. _____
- If the disability period exceeds two weeks prior to delivery or six weeks after the delivery, please give detailed medical information that supports the additional period of disability.
- Describe the disability - give diagnosis and detailed statement of patient's physical condition (Attach additional sheets if necessary.)

III. Physician Certification.

Physician's Name

Group Name

Suite | Daytime Telephone Number ( )

Street Address

Date Disability Begins			Estimated Date Disability Ends		
Month	Day	Year	Month	Day	Year

I certify that the above named patient is under my care. Adjustments in these dates may be necessary at a later date.

Physician's Signature (No Stamps, Please) | Date

SHBP 66-005 (Rev. 03/02)