



**Instructions.**

1. Read the directions on [ossburbank.com](http://ossburbank.com) regarding Disability Form Help.
2. Pay the fee for each disability form(s).
3. Hand in the agency's disability form (you must complete your section) or make sure you have included the EDD receipt number.
4. Fill out this form.

**Today's Date** \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_

EDD Receipt Number \_\_\_\_\_ Last 4 digits of your SS# \_\_\_\_\_ Your Email \_\_\_\_\_

Only for EDD. Look for a number that start with R10000XXXXXXXXXX

Only for EDD.

**Your Provider at OSS**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Stephan Yacoubian, MD | <input type="checkbox"/> Vaz Galstjan, PA-C | <input type="checkbox"/> Richard Feldman, MD |
| <input type="checkbox"/> Raymond Raven, MD     | <input type="checkbox"/> Omar Duenes, PA-C  | <input type="checkbox"/> Jeffrey Korchek, MD |
| <input type="checkbox"/> Shahan Yacoubian, MD  | <input type="checkbox"/> Angelo Smith, PA-C |  |
| <input type="checkbox"/> Yuri Falkinstein, MD  | <input type="checkbox"/> Katie Wong, PA-C   |  |
| <input type="checkbox"/> Mark Mikhael, MD      |   |  |

**Please pick 1.** I am requesting disability because my condition:

- ☐ Requires surgery. If yes, date of expected surgery \_\_\_\_\_
- ☐ Was caused by a sudden injury or accident. Date of Injury: \_\_\_\_\_
- ☐ No, NOT related to work. ☐ Yes, injury was during work.
- ☐ Is pain that grew over time or when I stopped working. Approximate date started: \_\_\_\_\_

**Please provide these dates:**

Last Date I Worked \_\_\_\_\_ 1st Date of Treatment for Issue with OSS Provider \_\_\_\_\_

Most recent date I came to OSS to treat this specific issue \_\_\_\_\_ Date my disability began \_\_\_\_\_  
Might be different than last date worked.

**Please pick 1.** Once OSS completes form, I want to:

- ☐ Pick up at office ☐ Have OSS mail directly to insurer / agency
- ☐ Have OSS email to me and then I will mail (Fastest! Most Reliable) Not Applicable for EDD.

**You are Done!**

**What to expect next?**

1. **Wait for OSS to do its part.** It will take OSS - the disability coordinator - **2 weeks** (10 business days) to complete.
2. **Want status?** Email us 10 days after submitting.

**OSS will fill out the section below**

Name of Disability Insurance(s) \_\_\_\_\_

Name of OSS Staff Member Accepting Income / Job Protection Disability Form & Date \_\_\_\_\_

Following Must be Complete To Hand Off to Disability Coordinator:

- ☐ Paid Fee Total Paid: \_\_\_\_\_
- ☐ EDD ☐ FMLA ☐ Private
- ☐ Completed this form
- ☐ Completed Agency Disability Form, Patient Section

Name of Disability Coordinator:

- ☐ Missy; [Mrivas@ossburbank.com](mailto:Mrivas@ossburbank.com) for Dr. Stephan Yacoubian
- ☐ Jose; [jcuriel@ossburbank.com](mailto:jcuriel@ossburbank.com) for Dr. Ray Raven
- ☐ Vanessa; [vanessac@ossburbank.com](mailto:vanessac@ossburbank.com) for Dr. Shahan Yacoubian, Dr. Yuri Falkinstein, Dr. Mark Mikhael
- ☐ \_\_\_\_\_