City of Omaha
Police and Fire Service Connected Disability

ENROLLMENT/CHANGE FORM

☐ **Newly approved SCD Participant - or -** ☐ **Existing Employee Change** ☐ **To Condition/Diagnosis** ☐ **To Medication** ☐ **To Address** ☐ **To Last Name**			
Date Form Completed:			
Effective Date of Enrollment/Change:			
Employee Name:			
ID#: (or SSN if ID unavailable)			
Date of Birth:		**Gender:** ☐ Male ☐ Female	
Address (Street):			
Address (City/St/Zip):			
Phone Number:			
APPROVED DISABILITY CONDITION:			
NEW ICD 10 DIAGNOSIS CODE(S):			

NEWLY APPROVED MEDICATIONS

If changing medications, please identify new medication name(s) and the medication(s) it will be replacing.

Drug Name	Quantity	Is this a Replacement to an Existing Drug?	If Yes, List Drug(s) Being Replaced
		Yes ☐ No ☐	
		Yes ☐ No ☐	
		Yes ☐ No ☐	
		Yes ☐ No ☐	
		Yes ☐ No ☐	
Additional Comments:			

Please email completed form to: Tim Cordell

CITY OF OMAHA INTERNAL USE ONLY

Approved By: _____