

APPLICATION FOR DISABILITY LEAVE WITH OR WITHOUT PAY

I. EMPLOYEE ONLY

This section is to be completed by the employee and then authorized by his/her physician.

Employee's Name:		Social Security Number:
Department:	Position Title:	Telephone Number:
Request disability leave beginning on:		Expect leave to continue until on or about:
REQUEST DISABILITY LEAVE TO BE USED AS: Sick Leave Substitute accrued annual leave Leave without pay		TYPE OF SICK LEAVE REQUEST Personal illness Injury Maternity Comments:
_____ Employee's Signature		_____ Date

II. PHYSICIAN ONLY

This section is to be completed by the employee's physician and then given to the employee to forward to his/her supervisor.

Expected Dates of Disability: Beginning: _____ Ending: _____ _____ Physician's Signature	Description of Disability: _____ _____ _____ _____ _____ Date
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III. SUPERVISOR ONLY

This section is to be completed by the recipient's and forwarded to the Human Resources Department.

Has the employee's entire earned sick/annual leave been exhausted?	Do you feel the employee has abused his/her leave? Yes No
Recommendation of action to the Director of Human Resources: _____ _____	
_____ Supervisor's Signature	_____ Date

IV. HUMAN RESOURCES ONLY

This section is to be completed by the Director of Human Resources.

Position Number:	Disability Leave Begin Date:	Disability Leave End Date:
Sick Days: Approved Disapproved	Annual Days: Approved Disapproved	Leave Without Pay Days: Approved Disapproved
Days without Leave Pay:	Projected Days Absent:	Total Days Absent:
Comments: _____ _____		
_____ Director of Human Resources Signature		_____ Date