



SHORT TERM DISABILITY REQUEST

(Non-Work Related Injury or Illness)

EMPLOYEE INFORMATION	
Name:	WFU ID Number:
Address:	Department:
City/State/Zip:	Supervisor:
DISABILITY INFORMATION	
Date first consulted physician in connection with this disability:	Name, address and phone number of physician:
Date you became unable to work as a result of this injury or illness:	
Have you been able to do any work since that date? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:	
When do you expect to return to work: <input type="checkbox"/> Full-time _____ / _____ / _____ <input type="checkbox"/> Part-time _____ / _____ / _____	
Comments:	
I understand I am to attach a completed copy of the Certification of Healthcare Provider Form.	
Employee Signature: _____	Date: _____
Use of Accrued Paid Time Off (PTO) During Short Term Disability	
<i>In accordance with HRPPM, Section X-4, Paid Time Off, staff employees may use PTO to supplement the Short Term Disability benefit provided an income is no greater than the base salary received prior to the non-work related illness or injury.</i>	
HUMAN RESOURCES DEPARTMENT USE ONLY	
<p style="text-align: center;"><u>ELIGIBILITY</u></p> <p><input type="checkbox"/> 12 months service</p> <p><input type="checkbox"/> Attending Physician Statement</p>	<p style="text-align: center;"><u>DATE RECEIVED BY HUMAN RESOURCES:</u></p> <p>Approval: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Comments:</p>