Office of Human Resources
Application for Temporary Disability Leave

Name: _____ SS#: _____

Department: _____ Title: _____

Leave from: _____ To: _____

Signature: _____ Date _____

Application for Leave must be attached

To be completed by your Attending Physician

Dates of Illness from: _____ to: _____
Date of first treatment: _____
Date of Last treatment: _____
Complete Diagnosis and findings:
_____
_____
_____

Date of the patient may return to work and assume **UNRESTRICTED** job responsibilities: _____

_____ _____
Physician's Signature Date

_____ _____
Physician's Name (print) Registration Number

_____
Address

_____ _____
Telephone Number (including area code) Fax Number

To be completed by Office of Human Resources

Leave Balance: _____ Days/Hrs as of _____ (date)
Date of leave with pay through: _____
Date of leave without pay begin: _____
Date of SLOAC/COBRA: _____

_____ _____
Signature of H.R. Officer Date