LE MOYNE
SPIRIT. INQUIRY. LEADERSHIP. *JESUIT.*

Office of Human Resources
1419 Salt Springs Road
Phone: 315.445.4155
Fax: 315.445.6023

Request for Disability Leave of Absence Form
(Faculty/Admin)

Employee's Statement
Absence Information

Employee Name: _____ SSN: _____

Address: _____

_____

Position: _____ Dept: _____ Ext: _____

Anticipated start date of disability: _____

Anticipated duration of disability: _____

Reason for disability: _____

_____

_____

Is disability a work-related injury: ☐ Yes   ☐ No

I have read the instructions above. I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled; and that the foregoing statements, including any accompanying statements, are to the best of my knowledge true and complete.

Employee Signature: _____ Date: _____

Employer's Statement

Date the completed claim form was received: _____

Date employee last worked: _____

Is disability due to a work-related injury?   ☐ Yes; Date of injury: _____   ☐ No

If maternity, date of birth: _____

Are wages being continued during disability?   ☐ Yes ☐ No

Date employee's wages ceased: _____

Date employee returned to work: _____

Signature: _____ Date: _____

Name: _____ Title: _____

For Office Use Only

Last Day Worked: _____   Delivery Date: _____
Return to work date: _____   ☐ C-section
                                                 ☐ Normal delivery

Physician's Statement
Proof of Claim for Disability Benefits

Claimant's Name: _____ Date of Birth: _____

Diagnosis/Analysis: _____

_____

Claimant Hospitalized?   From: _____ To: _____

Operations Indicated?   Type: _____ Date: _____

      a.   Date of your first treatment for this disability: _____

      b.   Date of your most recent treatment for this disability: _____

      c.   Date/Dates that claimant was unable to work because of this disability: _____

      d.   Date that claimant will be able to perform usual work: _____

In your opinion, is this disability a result of injury arising out of and in the course of employment or occupational disease? ☐ Yes; has form C-4/48 been filed with the board? _____ ☐ No

Remarks (Attach additional sheet if necessary): _____

_____

_____

I affirm that I am a: _____ Licensed in the State of: _____

License #: _____

Physician's Signature: _____ Date: _____

Physician's Name (Please print): _____ Phone #: _____

Office Address:

_____

_____