Employer's Statement of Disability

Employee Information

Employee Name:

[   ]

Employee ID/Number:

[   ]

Position/Job Title:

[   ]

Department:

[   ]

Date of Hire:

[   ]

Disability Information

Date Last Worked:

[   ]

Reason for Absence/Disability:

[   ]

Expected Return to Work Date:

[   ]

Employer Certification

Employer Representative Name:

[   ]

Title/Position:

[   ]

Contact Number:

[   ]

Signature:

[   ]

Date:

[   ]

[Submit]