Employeeâ€™s Statement of Disability

Employee Information

Full Name:

Employee ID:

Department:

Contact Number:

Disability Details

Date Disability Began:

Description of Disability:

Treating Physicianâ€™s Name:

Physicianâ€™s Contact Number:

Additional Information

Are you able to perform any work duties? Yes No

Anticipated Return to Work Date:

Certification

I hereby certify that the above information is true and correct to the best of my knowledge.

Employee Signature:

Date:

Submit