



Supervisor: Please fax to Human Resources at 580-5805 upon 6<sup>th</sup> lost work day.

### SHORT-TERM DISABILITY REPORTING FORM

INSTRUCTIONS FOR SUPERVISORS: Please complete Section A and fax to Human Resources by 6<sup>th</sup> lost work day. Upon employee's return to work: complete Section B on the date employee returns to work and fax to Human Resources.

**SECTION A: To be completed by the supervisor upon the employee's sixth lost workday, or earlier in cases where it is known that the absence will exceed 5 consecutive work days.**

Print Name (Last, First, M):	
Address:	
Home Phone:	
Department:	Job Title:
Scheduled # of Workdays Per Week:	Days: S M T W T F S
First Full Lost Workday Due to this Disability:	Expected Return Date (if known):
Attending Physician's Name (if known):	
Attending Physician's Address (if known):	
Brief description of Illness or Non-Work Related Injury:	
Supervisor's Signature:	Date:
Supervisor's Campus Extension:	

**SECTION B To be completed by the supervisor upon the employee's return to work**

Name of Employee:	Date Returned to Work:
Supervisor's Signature:	Date:

**SECTION C For Human Resources use only**

Date of Hire:	Account #:
Database Status Change:	<input type="checkbox"/> _____ <input type="checkbox"/> _____
First Seven (7) Calendar Days:	From: _____ To: _____
Number of Weeks/Days of Full Pay from the College:	
From:	To: