



Short Term Disability Request Form Personal Information

Name _____ Date of Birth _____
Address _____ E-mail Address _____
_____ Telephone _____
Social Security _____ Job Title _____

Short-term Disability Questionnaire

1. What dates are you unable to work due to disability? _____
2. Did you receive a diagnosis, medical care, services, treatment, advice or recommendations for this disability? Yes____ No____
3. If yes, what date did you or will you receive the following:
A. Diagnosis _____ B. Medical Care _____
C. Services _____ D. Treatment _____
4. Expected Return to Work Date? _____ (Attach FMLA and physicians documentation to form).

AUTHORIZATION TO DISCLOSE INFORMATION

(This Authorization complies with the HIPAA Privacy Rule)

I CERTIFY that the above statements are true, complete and correct to the best of my knowledge and belief. I understand that Wilberforce University will provide short term disability pay in an amount equivalent to seventy-five percent (75%) of the employee's regular weekly straight time pay beginning on the fifteenth (15th) day of disability and continuing through the ninetieth (90th) day of disability. I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, other medical or medically related facility or provider, clearinghouse, health plan, insurance or reinsuring company, agent, broker, service provider, credit bureau or other consumer reporting agency, employer, the Veterans Administration, the Medical Information Bureau, Inc., or any other personal or business associate to disclose any and all information related to said disability.

Signature _____

Date _____