

PATIENT SHORT TERM DISABILITY FORM

To Be Completed By Employee	
Name of Patient	Social Security Number
Date Last Worked	Employee Status (Part, Full or Temp)
I request consideration for short-term Disability pay for the following reason: <div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div>	
I affirm that the above statement is true and accurate	
Signature of Employee _____	Date _____

To Be Completed By Attending Physician		
Date First Examined Patient		
Clinical Diagnosis		
Primary: _____	ICD-9 Code	Pregnancy EDC
Secondary: _____		
Surgical Procedure(s) Performed		Date of Procedure
Date Disability Commenced	Expected Return To Work Date	
Restrictions		
<input type="checkbox"/> May not return to work at this time		
<input type="checkbox"/> May return to work/school with restrictions <input type="checkbox"/> No prolonged standing (over 15 minutes) <input type="checkbox"/> No heavy lifting (over 20 pounds)		
<input type="checkbox"/> Other: _____		
<input type="checkbox"/> May return to work at this time without restrictions.		
Attending Physician Signature _____		Date _____