

**Office of Human Resources  
Application for Temporary Disability Leave**

Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Department: \_\_\_\_\_ Title: \_\_\_\_\_

Leave from: \_\_\_\_\_ To: \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Chairperson/Supervisor's Signature: \_\_\_\_\_ Date \_\_\_\_\_

Division VP/Dean Signature: \_\_\_\_\_ Date \_\_\_\_\_

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**To be completed by your Attending Physician**

Dates of Illness from: \_\_\_\_\_ to: \_\_\_\_\_

Date of first treatment: \_\_\_\_\_

Date of Last treatment: \_\_\_\_\_

Complete Diagnosis and findings:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of the patient may return to work and assume **UNRESTRICTED** job responsibilities: \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Physician's Name (print) \_\_\_\_\_ Registration Number \_\_\_\_\_

\_\_\_\_\_  
Address \_\_\_\_\_

\_\_\_\_\_  
Telephone Number (including area code) \_\_\_\_\_ Fax Number \_\_\_\_\_

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**To be completed by Office of Human Resources**

Leave Balance: \_\_\_\_\_ Days/Hrs as of \_\_\_\_\_ (date)

Date of leave with pay through: \_\_\_\_\_

Date of leave without pay begin: \_\_\_\_\_

Date of SLOAC/COBRA: \_\_\_\_\_

\_\_\_\_\_  
Signature of H.R. Officer \_\_\_\_\_ Date \_\_\_\_\_