Contact HR-Leave Administration
E-mail: leaveadministration@uchicago.edu

SHORT-TERM DISABILITY (STD) LEAVE REQUEST

Before completing this form, please review Short Term Disability Policy 513
http://humanresources.uchicago.edu/fpg/policies/500/p513.shtml for eligibility requirements and complete conditions of STD leave. Please fax the completed form to 773-702-6098 or e-mail to leaveadministration@uchicago.edu

PLEASE PRINT

Name: _____ SSN: ***-***_____ Date of Birth: _____

Home/Mailing Address: _____

City, State Zip: _____ Home Phone: _____

E-Mail Address:_____

Job Title/Position: _____Department: _____ Supervisor's Name: _____

Hire Date: _____ Shift/Hours per week: _____ Date Last Worked: _____

Reason for Leave: Briefly describe the nature of your disability, non-work related injuries/illness, including pregnancy:

_____. Name of Hospital, if confined:_____

Date Admitted_____ Date Discharged: _____ Primary Physician: _____

IF THE DISABILITY WAS THE RESULT OF AN ACCIDENT, PLEASE COMPLETE THE FOLLOWING

Accident Date: _____ Time: _____ Where did it occur: _____
If Auto Related: Check If You Were the: Driver ___ Passenger ___ Pedestrian ___ Motorcyclist ___
Auto Insurance Co: _____ Claim No: _____
Other Insurance Co: _____ Claim No: _____
If injured on another's property, state address: _____
Property Insurance Co: _____ Claim No: _____

Date Leave to Begin: _____ Date Leave to End: _____

Accrual Election Option *Your STD leave is due to your own health condition, therefore, sick time will be applied first, you may request to apply other accruals during your STD leave. **Sick time must be exhausted before STD payments begin. **I request that HR-Leave Administration apply the following breakdown of accrued vacation and/or personal holidays for my STD leave: ___ # of vacation days ___ # of personal holidays ___ Use all of both**

PLEASE NOTE: If you have a qualifying life event, (e.g., birth/adoption of a child) during your STD leave, and you wish to add the child(ren) to your University of Chicago medical insurance, you must submit enrollment changes and required documentation within 31 days of the event date in Workday.

Employee Signature: _____ Date: _____

---------- OFFICE USE ONLY ----------

APPROVED ___ DENIED ___ BY: _____ Date: _____

HRS Leave Administration

NOTICE: Any falsification of or failure to produce requested information and supporting documentation may result in delay or denial of benefits and if warranted, disciplinary action up to and including discharge.

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ATTENDING PHYSICIAN'S STATEMENT

Physicians: Please print and complete with attention to detail. NOTE: "unknown, undetermined" are not acceptable as answers. Specific dates must be provided where indicated.

Employee name: _____

Diagnosis and concurrent condition(s): _____

ICD- 10 Diagnostic Code(s): _____

Has employee/patient been tested or treated for said conditions previously? If so, please indicate all dates:
_____

Date first examined for said condition(s): _____ Is the condition related to an accident? _____

Describe primary symptoms and significant objective findings: _____

_____

Hospitalized? State Admission/Discharge dates and attach admission and discharge summaries: _____

Did patient have or will surgery be scheduled: _____ If so, indicate date(s) and state type of surgery:

_____

Specific dates when seen for current condition(s): _____

Next Treatment/Examination Dates: _____

Is employee totally unable to work as a result of this condition? _____

As of what date do you consider the employee disabled from performing any job functions? _____

Expected date employee may return to:

Restricted Duty: _____ **For what period of time (# of days): _____**

State Restrictions: _____

_____

Regular Duty: _____ **Is this Estimated or Actual: _____**

Physician Name and Degree: _____

Address: _____ Phone: _____

City, State, Zip: _____ Fax: _____

Signature: _____ Date: _____

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NOTICE: An employee must be physically unable to perform all duties of his/her job and be under the care of a physician during the time period specified in this claim for disability benefits.

ACCRUAL INFORMATION SHEET

Please Print

Section 1

Employee should complete this section and give it to the H.R. Administrator responsible for your time card or monthly absence report.

Name: _____ SSN: ***-**_____ Department:_____

Section 2

HR Administrator/Supervisor should complete the following and return to the employee:

Hourly/Monthly Wage: _____ Last Day Worked: _____

Normal Work Schedule/Hours Per Week

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Sick Leave Accrued:_____ hrs. Vacation Accrued:_____ hrs. Personal Holiday: _____ hrs.

HR Administrator: _____
Please Print Name

Date: _____ Signature: _____

Supervisor Name: _____
Please Print Name

Date: _____ Signature: _____

****Return to Employee for submission to Leave Administration****
Leave Administration Fax number: 773-702-6098