

CONTINUED DISABILITY APPLICATION  
**\*\*\*PHYSICIAN'S STATEMENT/MEDICAL CERTIFICATION**  
**MUST BE ACCOMPANY THIS APPLICATION \*\*\***

Name: \_\_\_\_\_ SS#: \_\_\_\_\_ Dept.: \_\_\_\_\_

Sick Leave Balance: \_\_\_\_\_ Sick Leave Effective Date: \_\_\_\_\_ Date of Return \_\_\_\_\_

Briefly Explain Disability: \_\_\_\_\_

**WAITING PERIOD – FIVE (5) DAYS – MGMT**

**THREE (3) DAYS – 2937/3449**

**DATE \_\_\_\_\_ EMPLOYEE SIGNATURE \_\_\_\_\_**

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**FOR MANAGEMENT USE ONLY**

Hire Date: \_\_\_\_\_ Length of Service \_\_\_\_\_ # Of Weeks Allowed: \_\_\_\_\_

Union Group: **Mgmt / 2937 / 3449** Rate of Pay: \_\_\_\_\_ Waiting Period: \_\_\_\_\_

Disciplinary Actions: \_\_\_\_\_ Suspensions: \_\_\_\_\_

Effective Date of Continued Disability: \_\_\_\_\_

Approved: \_\_\_\_\_

DIRECTOR OF PERSONNEL

Disapproved: \_\_\_\_\_

DATE

Approved: \_\_\_\_\_

APPOINTING AUTHORITY

Disapproved: \_\_\_\_\_

DATE

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<u>LENGTH OF SERVICE</u>	<u>AVAILABLE WEEKS OF DISABILITY</u>
6 months to 1 year	10
1 year to 5 years	26
5 years to 15 years	36
15 years and over	52

ORIGINAL – AUDITOR  
CC Department Head  
Employee