Employerâ€™s Disability Claim Certification Form

Employee Information

Full Name

Employee ID

Job Title

Department

Date Hired

Last Day Worked

Disability Information

Type of Disability

Date Disability Began

Expected Return to Work Date

Additional Details

Employer Details

Employer Name

Address

Phone / Email

Certification

I certify that the above employee's statement is correct to the best of my knowledge.

Employer Signature

Date