Temporary Disability Insurance Form for Schools

Employee Information

| Full Name | |
|----------------------------------|--|
| Estate to a ID | |
| Employee ID | |
| Position/Title | |
| | |
| Department | |
| | |
| School Name | |
| Contact Number | |
| | |
| Email Address | |
| | |
| | |
| Disability Details | |
| Type of Disability | |
| | |
| Date Disability Began | |
| | |
| Expected Return Date | |
| Brief Description of Disability | |
| Biller Description of Disability | |
| | |
| | |
| | |
| Physician Information | |
| Physician Name | |
| | |

| Contact Number | |
|---------------------------|--|
| | |
| Physician's Comments | |
| | |
| | |
| | |
| Authorization & Signature | |
| Employee Signature | |
| | |
| Date | |
| | |