WAKE FOREST UNIVERSITY

Human Resources

SHORT TERM DISABILITY REQUEST

(Non-Work Related Injury or Illness)

EMPLOYEE INFORMATION	
Name:	WFU ID Number:
Address:	Department:
City/State/Zip:	Supervisor:
Phone:	Supervisor Phone:

DISABILITY INFORMATION	
Date first consulted physician in connection with this disability:	Name, address and phone number of physician:
Date you became unable to work as a result of this injury or illness:	
Have you been able to do any work since that date? ☐ Yes ☐ No If yes, explain:	
When do you expect to return to work: ☐ Full-time _____/_____/_____ ☐ Part-time _____/_____/_____	
Comments:	
I understand I am to attach a completed copy of the Certification of Healthcare Provider Form. Employee Signature: Date:	

Use of Accrued Paid Time Off (PTO) During Short Term Disability

In accordance with our Paid Time Off policy, staff employees may use PTO to supplement the Short Term Disability benefit provided an income is no greater than the base salary received prior to the non-work related illness or injury.

HUMAN RESOURCES DEPARTMENT USE ONLY	
ELIGIBILITY:	DATE RECEIVED BY HUMAN RESOURCES:
☐ 12 months service ☐ Attending Physician Statement	Approval: ☐ Yes ☐ No Comments: