Livingston EDUCATIONAL SERVICE Agency

# APPLICATION FOR SHORT-TERM DISABILITY BENEFITS

To request Short-Term Disability benefits, please complete the following request form and submit to Jenn Damon, Human Resources.

Name: _____
*First Name* *Last Name*

Address: _____
*Street* *City* *State* *Zip*

Telephone Number: _____ Email Address: _____

For Illness, Injury or Pregnancy, please answer the following question(s):

Date you were first treated for a physician:

_____
*MM/DD/YY*

Physician's Name: _____

Physician's Address: _____

Physician's Telephone Number: _____

Date you were first unable to work:

_____
*MM/DD/YY*

Did you work a full day? ☐ Yes ☐ No

If "No", please explain: _____

Do you expect to return-to-work? ☐ Yes ☐ No

☐ Part-time *(date)*: _____
*MM/DD/YY*

☐ Full-time *(date)*: _____
*MM/DD/YY*

Additional information about employee FMLA rights and responsibilities will be provided to you in writing within five business days after receipt of this notice (unless already provided).

Determination of eligibility for leave under the FMLA, and/or additional documentation or clarification of documentation may be required prior to making a final FMLA determination to approve or deny an FMLA leave request.

Please contact Human Resources with any questions.

**Electronic Signature Agreement:** By selecting the "I Accept" button, you are signing this document electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this document. You further agree that your signature on this document is as valid as if you signed the document in writing. ☐ I Accept.

Signature: _____

Date Signed: _____
[mm/dd/yyyy]

**FOR HR USE ONLY** Date received: _____