Bryn Mawr College

Short-Term Disability Application

Name__________________________________ ID #____________________________

Department_____________________________ Date of Hire____________________

Primary
Diagnosis*____

Secondary Diagnosis* (if any)____

First Date that you were unable to work as the Result of Illness or Injury

____

Expected Date of Return (if known)_______________________________________

Primary Health Care Provider (the provider who should be contacted with any questions regarding your treatment)

Name____

Address____

____

Phone Number(_____)__________________

I have read and understand the attached Bryn Mawr College Short-Term Disability Policy effective January 1, 2007, and agree to abide by its terms:

_______________________________________ _______________________________
Employee Signature Date

This application is not deemed complete without accompanying medical certification.

*Do not provide any genetic information when completing this application.