Form HR39615

AFSCME NOTICE AND PROOF OF DISABILITY

FOR EMPLOYEES REPRESENTED BY AFSCME

UNIVERSITY OF MICHIGAN

To be completed by staff member upon return to work.

Name		
Date	UMID	
I certify that I was unable to work because of a disability resulting from ☐ Personal Sickness ☐ Injury		
From	Date	Time
To	Date	Time
Total time lost from work in hours		
Nature of Disability		
I was under the care of a physician. Physician's Name:		I was not under the care of a physician.
Advance Notice Given To:	Time and Date Notice Given:	
I did not give advance notice because:		
Staff Member's Signature:	Date	

To be completed by staff member's department.

☐ Approved ☐ Disapproved	Date
Name of Supervisor	Signature of Supervisor
Reasons for disapproval (if applicable) or other comments	
A physician's statement will be required as verification that you are unable to work because of personal sickness or injury prior to being considered for any future sickness or injury pay.	