

AFSCME NOTICE AND PROOF OF DISABILITY
FOR EMPLOYEES REPRESENTED BY AFSCME



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 <input type="checkbox"/> Personal Sickness <input type="checkbox"/> 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.

<input type="checkbox"/> Approved	<input type="checkbox"/> 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.		