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.