



**EASTERN
MENNONITE
UNIVERSITY**

Short-term Disability Claim Form

EMPLOYEE INFORMATION

NAME:				
Last	First	MI		
HOME ADDRESS:				
Street	Apt.	City	State	Zip
DATE OF BIRTH: __ / __ / ____	HOME PHONE: (____) ____ - ____	GENDER: Male <input type="checkbox"/> Female <input type="checkbox"/>		

I authorize any licensed physician who has examined or treated me to complete the necessary information on this form for Eastern Mennonite University and to determine if my medical condition should qualify me for disability benefits.

Signature

Date

PHYSICIAN INFORMATION

NAME:		OFFICE PHONE:	FAX:
Last	First		
ADDRESS:			
Street	Suite	City	State Zip

MEDICAL INFORMATION

Failure of the physician to provide full and complete information or to provide follow-up information to Eastern Mennonite University will cause a delay in or cancellation of disability benefits for the patient.

Is this <input type="checkbox"/> an original claim? <input type="checkbox"/> an extension of a previous claim? <input type="checkbox"/> a work related injury?		
Primary Diagnosis:		Diagnosis Code:
Date of illness or injury (first diagnosis): __ / __ / ____	Date diagnosed as totally disabled: __ / __ / ____	Date of next examination: __ / __ / ____
Prognosis (is patient expected to recover; if so, when?; etc);		
What are the patient's present limitations? (be specific)		

I certify that I have personally examined the above patient and the information contained in this form is true and accurate to the best of my knowledge.

Physician Signature

Date