

Return this from to:

HR Shared Services
 621 Skytop Road, Suite 1001
 Syracuse, NY 13244
leaveadmin@syr.edu
 Phone: 315.443.4042
 Fax: 315.443.1063

Pages one and two of this form should be completed by the employee.

Pages three and four must be completed by the employee's physician.

EMPLOYEE INFORMATION (please print or type)

Full name (Last, First)		SUID	
Address			Phone#
Date of Birth		Male <input type="checkbox"/>	Female <input type="checkbox"/>
List the duties of your occupation at the time of disability:			
I have been unable to work because of this disability since: (Month/Day/Year)	I returned to work on a part- time basis: (Month/Day/Year)	I returned to work on a full- time basis: (Month/Day/Year)	
Date of your accident or date you first noticed the symptoms of your injury/illness: (Month/Day/Year)	Is your injury/illness related to your occupation? Yes <input type="checkbox"/> No	If yes, explain:	
Describe how and where accident occurred or describe the first symptoms of your injury/illness:			
Date you were first treated for your illness or injury: (Month/Day/Year)	Treated by Physician - Name and Address: Hospital Name and Address		

Have you ever had the same or similar condition in the past? Yes No	Treated by Physician - Name and Address: Hospital Name and Address:
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Describe any other income you are receiving or are eligible to receive as a result of your disability:

Source of Income	Amount of Income	Date Income Began	Date Income Ended

The above statements are true and complete to the best of my knowledge and belief. I hereby authorize any hospital or physician who has treated me, or person who has attended me or examined me, or any company or government agency, to furnish to Syracuse University or its representative, any and all information with respect to any illness, medical history, consultations, prescriptions, treatments of benefits, and copies of all applicable records. A copy of this form will be as valid as the original.

Employee Signature

Date

ATTENDING PHYSICIAN'S STATEMENT - ACCIDENT/ILLNESS/MATERNITY

1. Patient's Name	Age	Date symptoms first appeared or the accident happened:
2. Nature of Injury or Illness - Diagnosis (describe complications if any)		
3. Is condition due to injury or illness arising out of patient's employment? If "Yes", explain.		Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Date patient first consult you for this condition?		
5. Has patient ever had same or similar condition? If "Yes", state when and describe.		Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Describe any other injury/illness affecting present condition.		
7. Nature of surgical or obstetrical procedure, if any. (describe fully)		Date:
8. Dates of treatment: Office _____ Home _____ Hospital _____		
9. If patient hospitalized, name and address of hospital:		Date Admitted:
Name _____		_____
Address _____		Date Discharged:
_____		_____
10. How long was or will patient be continuously totally disabled (unable to work)?		
From: _____, Yr. _____ Through _____, Yr. _____		
11. How long was or will patient be partially disabled?		
From: _____, Yr. _____ Through _____, Yr. _____		
12. Is the patient competent to endorse checks and direct the proceeds with a clear understanding of the nature of his acts?		

