

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.

*Do not provide any genetic information when completing this application.