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| **Short Term Disability**  **Tracking Number:**  **Short Description:** |
| |  |  |  |  | | --- | --- | --- | --- | | **Employee Information :** | | | | | Employee :\* |  | | | | Department No : |  | Executive : |  | |
| |  |  |  |  | | --- | --- | --- | --- | | **Short Term Disability Information** | | | | | Note: Employees are on STD when their absence is expected 7 calendar days and their illness or injury prevents them from doing their job. This form should be submitted as soon as it is known that the absence is expected to exceed 7 calendar days | | | | | STD Effective Date (DD-MM-YYYY) :\* |  | STD Eligibility Date: |  | | Action STO : |  | Reason STO : |  | | **Note: Employees are not required to reveal medical reason for disability to their manager. Medical reason will be revealed to our Short Term Disability vendor at a later date. STD is effective the first day of absence.** | | | | | Is this a work related illness/injury : | Yes No |  |  | |
| |  |  |  |  | | --- | --- | --- | --- | | **Return From Short Term Disability Information** | | | | | Please do not complete this section until the employee has physically return to work. Reminder: BEFORE the employee begins working the employee must present a doctor's note to the manager permitting the employee to return to work. | | | | |  | | | | | Did employee return to work full-time?: | Yes No | | | |  | | | | | Date Employee Return To Work (DD-MM-YYYY) : |  |  |  | | Action RFD : |  | Reason RFD |  | | No Of Working Hrs per day : | (HH24:MM) | Day Of Absence |  | |  | | | | | **The Information regarding the employee's partial disability benefits will be send to Decision One by The Standard Insurance Company. Please submit this form ONLY when the employee has returned to work full time** | | | | | |