



City of Mishawaka

David A. Wood, MAYOR

DEPARTMENT OF HUMAN RESOURCES
Bonnie Bonham, Human Resources Director

600 E. Third Street, Room 203
(574)258-1615, FAX 254-0197

LONG TERM DISABILITY

Dear Physician:

Our employee _____ (see attached job description) for the City of Mishawaka is requesting medical disability for employment. To assist us in determining pay under our Long-Term Disability Plan we need you to complete **all** of the following sections and return this form to Human Resources, City of Mishawaka, 600 E. Third St., Mishawaka, IN 46544. Failure to send this form in a timely manner could lead to denial of benefits to the employee. Thank you for your cooperation.

SECTION I.

1. Condition or Diagnosis _____
2. Date authorized for disability to begin _____ Leave is for _____ days _____ weeks
3. Date authorization ends _____
(If unknown, give approximate date for the earliest return. Authorization can always be extended.)

SECTION II.

- A. Employee is totally disabled and unable to perform his/her job. **Do not** check this box if employee is **able** to perform his/her job on a limited basis; instead check B or C.
- B. Employee is partially disabled, but can perform his/her job with restrictions. (List restrictions)

- C. Employee can work partial days. (State number of hours per day employee can work): _____ hours
- D. Employee can work full-time without restrictions

SECTION III.

1. Follow up appointment date: _____
2. Goals of Treatment: _____
3. Anticipated treatment plan: _____

Physician's Printed Name

Physician's Signature

Date

Physician's Address

Physician's Phone

Physician's FAX