**Long-Term Disability Leave Application Form**

**Purpose:** Use this form to apply for long-term disability leave. Submission of supporting medical documentation is required.

1. **Employee Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Employee Name |  | | |
| Employee ID |  | Department |  |
| Position / Job Title |  | Contact Number |  |
| Email Address |  | Supervisor / Manager Name |  |

1. **Leave Request Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Type of Leave Requested | Long-Term Disability Leave | Leave Start Date |  |
| Expected Return Date |  | Total Duration Requested |  |
| Reason for Leave (brief summary) |  | | |

**C. Medical Certification**

**Note:** Attach relevant documentation from a licensed healthcare provider.

|  |  |  |  |
| --- | --- | --- | --- |
| Treating Physician Name |  | Contact Information |  |
| Diagnosis (if comfortable sharing) |  | Date of Onset of Disability |  |
| Anticipated Duration of Disability |  | Physician Signature & Date |  |

**Attachment Checklist:**

* ☐ Medical certificate / doctor’s note
* ☐ Treatment plan (if applicable)
* ☐ Other supporting medical documentation

**D. Employee Acknowledgment**

I certify that the information provided is accurate and complete. I understand that submission of this form does not guarantee approval of leave and that all applicable company policies will be followed.

|  |  |  |
| --- | --- | --- |
| **Employee Signature** |  | **Date** |

**E. Supervisor / HR Review**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Reviewer** | **Position** | **Comments** | **Approved / Denied** | **Signature** | **Date** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**F. Notes / Instructions**

1. Submit this form to HR at least 30 days prior to the expected leave start date, if possible.
2. Include all required medical documentation to prevent delays.
3. HR will contact the employee regarding approval and any additional requirements.