**Short-Term Disability Leave Application Form**

**Purpose:** For requesting temporary leave due to a non-work-related medical condition.

1. **Employee Information**

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

1. **Leave Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Type of Leave | Short-Term Disability (Medical) | Reason for Leave | Temporary medical disability (non-work-related) |
| Start Date |  | End Date |  |
| Total Duration |  | Is intermittent leave required? | ☐ Yes ☐ No |

1. **Medical Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Treating Physician |  | Physician Contact |  |
| Diagnosis / Medical Condition (brief) |  | Medical Certification Attached? | ☐ Yes ☐ No |
| Additional Notes |  | | |

**D. Employee Declaration**

I hereby certify that the information provided above is true and accurate. I understand that this leave request is subject to approval according to company policies and applicable laws.

**Employee Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Supervisor / HR Use Only**

|  |  |  |  |
| --- | --- | --- | --- |
| Approved / Denied | ☐ Approved ☐ Denied | Comments |  |
| HR Representative |  | HR Signature |  |
| Date |  |  |  |