



The University of Michigan Notice and Proof of Disability

To be completed by staff member upon return to work.

Name		
Date	UMID	
I certify that I was unable to work because of a disability resulting from <input type="checkbox"/> Personal Sickness <input type="checkbox"/> Injury <input type="checkbox"/> FCARE <input type="checkbox"/> PRESC (formerly PMED/PDENT)		
From	Date	Time
To	Date	Time
Total time lost from work in hours		
Nature of Disability		
<input type="checkbox"/> I was under the care of a physician. Physician's Name: _____ <input type="checkbox"/> I was not under the care of a physician.		
Advance Notice Given To:	Time and Date Notice Given:	
I did not give advance notice because:		
Staff Member's Signature:	Date	

To be completed by staff member's department.

<input type="checkbox"/> Approved	<input type="checkbox"/> Disapproved	Date
Name of Supervisor	Signature of Supervisor	
Reasons for disapproval (if applicable) or other comments		
<input type="checkbox"/> A physician's statement will be required as verification that you are unable to work because of personal sickness or injury prior to being considered for any future sickness or injury pay.		

Copy to Plant Operations Health and Wellness Coordinator for confidential data collection.