



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		
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.	