

Kenneth J. Sobel, M.D.

PATIENT SHORT TERM DISABILITY FORM

TO BE COMPLETED BY EMPLOYEE		
Name of Patient	Social Security Number	
Date Last Worked	Employee Status (Part, Full or Temp)	
I request consideration for short-term Disability pay for the following reasons: _____ _____		
I affirm that the above statement is true and accurate _____ Signature of Employee		
_____ Date		
TO BE COMPLETED BY ATTENDING PHYSICIAN		
Date First Examined Patient		
Clinical Diagnosis	ICD-9 Code	Pregnancy EDC
Primary: _____	_____	_____
Secondary: _____	_____	_____
Surgical Procedure(s) Performed	Date of Procedure	
Date Disability Commenced	Expected Return To Work Date	
Restrictions		
<input type="checkbox"/> May not return to work at this time		
<input type="checkbox"/> May return to work/school with restrictions		
<input type="checkbox"/> No prolonged standing (over 15 minutes)		
<input type="checkbox"/> No heavy lifting (over 20 pounds)		
<input type="checkbox"/> Other: _____		
<input type="checkbox"/> May return to work at this time without restrictions		
_____ Attending Physician Signature		_____ Date