DISABILITY SUPPLEMENTAL INFORMATION

Employee's Name:
Claim Number:
Agency:Payroll #:
Information is for:
☐ Extension ☐ Reinstatement NEW Date Last Worked:
Date Employee <u>ACTUALLY</u> returned to work:
Agency Recommendation: Approval Disapproval Dr. Review (send PD)
Reason for disapproval or Dr. review:
Allow light/modified duty:
If yes, temporary modifications that can be made to job:
Comments:

Agency Contact: Phone #:
(Appointing Authority or Designee Signature) Date