Savannah River NUCLEAR SOLUTIONS℠
FLUOR • NEWPORT NEWS NUCLEAR • HONEYWELL

Initial Notification of Request for Short-Term Disability

Phone: 803.725.SICK **Email:** 5SICK@srs.gov **Fax:** 803.952.9663

Please fill out the information below and return this form to the 5-SICK Disability Dept.

Date: ____________________ **Company:** ____________________

User ID: ____________________ **Emp Name:** ____________________

Email: ____________________ **Shift:** ____________________

Home Phone: ____________________ **Alt. Phone:** ____________________

Manager Name: ____________________ **Manager Phone:** ____________________

Summary/Reason for Disability:

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First Date Out of Work: ________________ **Anticipated Return to Work Date:** ________________

Treating Physician: ____

Treating Physician's Diagnosis/Reason for Disability:

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If Applicable

Hospital Admission Date: ________________ **Hospital Discharge Date:** ________________

IMPORTANT INFORMATION

- Call 5SICK with an update after each doctor visit AND prior to returning to work to schedule a return appointment with site medical.
- Provide a copy of your office/ER visit with a work excuse to include ALL dates of disability requested – including the 40 hours wait period. STD will not be approved without the requested documentation.
- Keep manager informed of your disability date and return to work date.

To be filled out by DCM ONLY:

STD approved after 40 hour waiting period beginning ________________________.

Return to work date: ______________________________