

Short Term Disability Application

Moore College of Art & Design
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 Fax (215) 568-5017

A. Information about the Employee

Employee Name	Social Security Number	Date of Birth	
Address	City, State, Zip		
Telephone Number	Date of Hire	Monthly Salary	Last Day worked
	<input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced
Occupation			

B. Information about the Conditions causing your disability

1. What were your first symptoms?	
2. When did you notice them?	3. Date you were first treated by a physician (Month, Day, Yr.)
4. Why are you unable to work?	
5. Before you stopped working, did your condition require you to change your occupation or the way you did your occupation <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Have you filed, or do you intend to file a workers' compensation claim?	
FOR AN INJURY, ANSWER THE FOLLOWING QUESTIONS	
7. Where and how did the injury occur?	
8. Date the injury occurred (Month, Day, Yr)	9. Date you were first treated for this injury by a physician (Month, Day, Yr)