MOODY BIBLE INSTITUTE

SHORT TERM DISABILITY BANK - CERTIFICATION OF PHYSICIAN

1. Employee's Name:_____

Physician: Please complete #s 2-13:

2. Diagnosis (in WORDS—NOT code numbers)_____

_____

_____

3. Date condition commenced (specific treatment dates):_____

4. Date Condition ended:_____

5. Date employee may return to work:_____ Restrictions?_____

6. Date employee was hospitalized (~~overnight~~ hospitalization only; ER with ~~no overnight stay~~ does not apply):_____

7. Does the patient's condition qualify under any of the categories listed below? If so, please check the applicable category: (1) _____ (2) _____

   (1) The patient had _____ out-patient surgery or _____ out-patient treatment in a hospital or out-patient surgical/trauma center (excludes doctor's office) in which he or she was not required to stay overnight, but was required by his or her physician to be off work for at least five days.

   (2) The patient had treatment in a hospital or out-patient surgical/trauma center (excludes doctor's office) for an extended and serious life-threatening illness (i.e., cancer, kidney disease, heart condition, mental health, etc.).

8. Date of outpatient surgery _____or treatment in a hospital or out-patient surgical or medical center _____

9. Additional comments (e.g., restrictions on return to work, etc.)_____

_____

_____

10. Physician's signature:_____ 11. Date:_____

12. Physician's name (printed):_____ 13. Phone number: (_____)_____

14. Employee's signature:_____ 15. Date:_____

16. Human Resources approval: _____ 17. Date:_____

Please return this form to Human Resources, MBI, 820 N. LaSalle Blvd., Chicago, IL 60610
ATTENTION: Erica Loring, erica.loring@moody.edu **or FAX** at (312) 329-2151
** Forms need to be received no later than last day in pay period to receive time off**