Instructions for Anticipated Disability Leave of Absence (ADL) Application

Mid-Atlantic Bargained for Employees

Please review the Conditions for Leave within the Anticipated Disability Leave Guidelines. Your supervisor should review the Conditions for Leave with you before you sign this application.

Leaves over 30 calendar days must be entered into Manager's Self Service (MSS) by the employee's supervisor.

Part 1: **Employee Information** Please provide all required information. If you are not sure of the answer to some of the information requested, for example your net credited service date, ask your supervisor.

Part 2: **Request for Leave** Please provide the dates you would like for your leave to begin and end. You can take up to twelve (12) months of Anticipated Disability Leave. A minimum of one full day of leave, unpaid and non-disabled, must occur before the actual disability.

Part 3: **Acknowledgements** After your supervisor has reviewed the Conditions for Leave with you; you, your supervisor and Director must sign this section.

After completing the application, please make a copy and keep it for your records. Mail or fax the completed application including the **Attending Physician's Report of Anticipated Disability** to the Leave of Absence Team for review.

Please submit completed application to:

LOA Administrator
500 Summit Lake Drive, 3rd Floor
Valhalla, NY 10595
Fax: 1-877-660-2660

If you have any questions, please contact 1-800-638-4228 or send an e-mail to verizonleavemanagement@Sedgwickcms.com

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Anticipated Disability Leave
Fax Cover Sheet

CONFIDENTIAL AND PRIVATE

To: Verizon Leave of Absence Team

Fax: 1-877-660-2660

Date: _____

Employee Name: _____

EMPLID: _____

First Day of Leave: _____

Number of Pages (including cover sheet): _____

Verizon Leave of Absence Team
500 Summit Lake Drive
3rd Floor
Valhalla, NY 10595

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Attending Physician's Report of Anticipated Disability
(Mid-Atlantic Bargained for Employees)

20-1168
2018

Name (Last, First, Middle Initials)	NCSD	EMPLID
Job Title	Home Address	Telephone No. (Include Area Code)
Start Date of Leave:		

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Physician Name	Telephone No. (Include Area Code)
Address	

To Dr. _____

You are hereby authorized and requested to furnish all necessary information concerning my anticipated disability to Verizon. Please retain a copy for your records and return the original in the envelope provided.

_____ _____

Employee Signature Date

ATTENDING PHYSICIAN'S REPORT

ANTICIPATED DISABILITY IS DUE TO:

☐ Pregnancy — Estimated Date of Delivery: _____

☐ Anticipated Surgery — Estimated Date of Surgery: _____

Type of Surgery: _____

☐ Other (explain): _____

_____

Estimated First Date of Disability: _____

Estimated Recovery Period: _____

_____ _____

Physician Signature Date

RETURN COMPLETED FORM TO: **LOA Administrator**
500 Summit Lake Drive, 3rd Floor
Valhalla, NY 10595
Fax: 1-877-660-2660
If you have any questions, please contact 1-800-638-4228 or send an e-mail to verizonleavemanagement@Sedgwickcms.com

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Application for Anticipated Disability Leave of Absence (Mid-Atlantic Bargained for Employees)

20-1168-ADL
2018

Part 1: Employee Information	
Employee Name:	
Employee's EMPLID:	**Employee's NCSD:**
Employee's Address during Leave:	**Employee's Telephone # during Leave:**
Department Contact:	**Department Contact Telephone #**
Supervisor's Name:	**Director's Name:**

Part 2: Request for Leave (Please check all that apply)

☐ Full Time Leave, to begin on ___/___/_____ and to continue through ___/___/_____

Part 3: Acknowledgements

I hereby apply for an Anticipated Disability Leave of Absence, in accordance with the Company's Anticipated Disability Leave of Absence Guidelines and subject to the Conditions for Leave. I have read and understand these conditions.

Employee Signature:	Date:

The above employee has applied for an Anticipated Disability Leave of Absence. I have reviewed the Anticipated Disability Leave of Absence Guidelines and the Conditions for Leave with the employee.

Supervisor Signature:	Date:
Director Signature:	Date:

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