Instructions for Anticipated Disability Leave of Absence (ADL) Application

New York and New England 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 six (6) 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

Application for Anticipated Disability Leave of Absence
(New York and New England Bargained for Employees)

G2518 - 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 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:

Attending Physician's Report of Anticipated Disability

G2518 - ADL
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

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