CenturyLink™

Time Away From Work
Phone: 888-722-4372
Fax: 913-397-3744

Extension Form
For Short Term Disability

TO BE COMPLETED BY EMPLOYEE			
Employee's Full/Legal Name	Social Security Number: Employee ID Number:	Employee Date of Birth	Phone Number Personal Email Address

TO BE COMPLETED BY HEALTH CARE PROVIDER <u>ONLY IF YOUR ABSENCE IS GOING TO CONTINUE PAST YOUR ORIGINAL RETURN TO WORK DATE</u>

1. State diagnosis or if no diagnosis has been determined, describe the medical facts such as symptoms, diagnosis, or continuing treatment that will extend the employee's absence. Provide all factors delaying recovery.

2. ICD9 Primary disease code:_____ Secondary: _____

3. Date the employee was first unable to perform his/her job due to disability: _____/_____/_____

4. The extended date you anticipate releasing patient to regular work: _____/_____/_____ (**unknown & indefinite are not acceptable answers**)

5. Health Care Provider's name as it appears on License (Please Print) _____

   License number _____

   Office Phone # _____-_____-_____ Office Fax # _____-_____-_____

   Health Care Provider's address _____

6. Health Care Provider's Certification and signature (required): Having considered the patient's regular and customary work, certify under penalty of perjury that based on my examination, this Health Care Provider's Certificate truly describes the patient's Disability (if any) and the estimated duration thereof.

I further certify that I am a _____ Licensed to practice in the state of _____
(Type of Practice/Specialty)

_____ _____
Original signature of Health Care Provider Date signed
(rubber stamp is not acceptable)