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 and your supervisor 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
111 Main Street, 6th Floor
White Plains, NY 10601
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
2019

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 one)

Nature of Anticipated Disability ☐ Surgery ☐ Pregnancy ☐ Other

Note: Requested first day of leave must be at least one day prior to the anticipated disability and a scheduled work day.

Full Time Leave, to begin on ____/____/______ and to continue through ____/____/______

Estimated Date Disability Will Begin ____/____/______

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:

Attending Physician's Report of Anticipated Disability

G2518 - ADL
2019

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

☐ Anticipated Surgery

Estimated Date of Delivery: ______________________________

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
111 Main Street, 6th Floor
White Plains, NY 10601
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
111 Main Street
6th Floor
White Plains, NY 10601