

**Disability Request Form**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ Company: \_\_\_\_\_

Please provide us with a brief description of your current work duties:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date disability to begin (or began): \_\_\_\_\_

Estimated date you plan to return to work: \_\_\_\_\_

Do you plan on returning to part-time or restricted work (prior to full-time, full release work): (please circle) **YES** or **NO**

If yes, please provide that estimated date of return: \_\_\_\_\_

How would you like to receive your completed forms? (please circle)

**Pick Up at Office** or **Mail** or **Fax**

Please provide mailing address: \_\_\_\_\_

Please provide fax #: \_\_\_\_\_

**PLEASE REMEMBER THESE IMPORTANT ITEMS WHEN COMPLETING REQUEST:**

- Please call the disability message line 720-494-3235 for further questions
- Please allow 10-14 days to complete the paperwork
- \$20 Charge, per form completed (prepayment required)

**Official Use Only:**

Dr. \_\_\_\_\_

Account # \_\_\_\_\_

Amount Paid \$: \_\_\_\_\_