

DEPARTMENT DISABILITY NOTICE

HOME DEPT. NAME:		HOME DEPT NO:	
WORK DEPT. NAME:		WORK DEPT. NO:	
SUPERVISOR'S NAME:		SUPERVISOR'S EXT:	
EMPLOYEE'S NAME		EMPLOYEE'S NUMBER	
EMPLOYEE'S JOB TITLE		SOCIAL SECURITY NUMBER	
SALARY AS OF THE LAST COMPLETED PAYROLL PERIOD, EXCLUDING OVERTIME AND OTHER ADDITIONAL COMPENSATION PER <input type="checkbox"/> MONTH <input type="checkbox"/> HR \$ _____		<input type="checkbox"/> FULL TIME HOURS PER DAY <input type="checkbox"/> 7.5 <input type="checkbox"/> 8 <input type="checkbox"/> PART TIME <input type="checkbox"/> OTHER IF PARTIME, % TIME _____	
IF FACULTY IS PAY BASED ON A 9 OR ON A 12 MONTH CONTRACT? _____			
ACCOUNT NUMBER REGULARY PAY _____ <input type="checkbox"/> STAFF <input type="checkbox"/> FACULTY			
SALARY/WAGES PAID ON BASIS OF: <input type="checkbox"/> FISCAL YEAR <input type="checkbox"/> ACADEMIC YEAR <input type="checkbox"/> TERM <input type="checkbox"/> OTHER (EXPLAIN) _____			
LAST DAY EMPLOYEE WAS PHYSICALLY PRESENT AT WORK: _____			
HAS EMPLOYEE TERMINATED? <input type="checkbox"/> NO <input type="checkbox"/> YES, ON _____			
THROUGH WHAT DATE HAS EMPLOYEE BEEN PAID OR WILL BE PAID WAGES OR SALARY BY DEPT? _____			
USC HIRE DATE _____ WAS EMPLOYEE A TEMPORARY WORKER BEFORE THIS DATE? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, ENTER DATE WHEN EMPLOYED AS A FULL TIME REGULAR _____			
HAS THE EMPLOYEE BEEN AN ACTIVE FULL TIME EMPLOYEE CONTINUOUSLY FOR 12 MONTHS PRIOR TO THE LAST DAY HE/SHE WAS PHYSICALLY PRESENT AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO			
HAS SICK LEAVE BEEN PAID SINCE EMPLOYEE WAS LAST PHYSICALLY PRESENT AT WORK? <input type="checkbox"/> NO <input type="checkbox"/> YES, FROM _____ THRU _____			
HAS VACATION BEEN PAID SINCE THIS DATE? <input type="checkbox"/> NO <input type="checkbox"/> YES, FROM _____ THRU _____			
HAS EMPLOYEE RETURNED TO WORK SINCE THIS DATE? <input type="checkbox"/> NO <input type="checkbox"/> YES, ON _____			
DID EMPLOYEE SUFFER A WORK RELATED INJURY? <input type="checkbox"/> NO <input type="checkbox"/> YES, ON _____			
WAS EMPLOYEE LAID OFF WORK DURING THE PAST 12 MONTHS PRIOR TO DISABILITY (EVEN AS A REGULAR LAYOFF)? <input type="checkbox"/> YES <input type="checkbox"/> NO			
WAS EMPLOYEE ON DISABILITY LEAVE FOR MORE THAN 14 CONSECUTIVE DAYS, A LEAVE OF ABSENCE FOR MORE THAN 30 CONSECUTIVE DAYS, OR AN APPROVED SABBATICAL OR SPECIAL FULTY LEAVE FOR MORE THAN 1 YEAR DURING THE PAST 24 MONTHS IMMEDIATELY PROCEEDING THE CURRENT DISABILITY? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, PLEASE GIVE DATES _____			
IF EMPLOYEE LAID OFF DURING PAST 12 MONTHS, FOR WHAT PERIOD? _____ THRU _____			
PERSON PREPARING THIS NOTICE:	TITLE	PHONE	SIGNATURE
			DATE
IT IS THE DEPARTMENT'S RESPONSIBILITY TO END THE FUNDING LINE(S)		IMPORTANT: SEND ORIGINAL OF THIS FORM TO THE DISABILITY OFFICE (HSH300, MC 1058).	
REMARKS:			