



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
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**TO BE COMPLETED BY HEALTH CARE PROVIDER ONLY IF YOUR ABSENCE IS GOING TO CONTINUE PAST YOUR ORIGINAL RETURN TO WORK DATE**

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  
(rubber stamp is not acceptable)**

\_\_\_\_\_  
Date signed