SOUTHEAST
PERSONNEL LEASING, INC.

DISABILITY CLAIM INFORMATION FORM

Claimant's Name _____ SS# _____

Actual Last Day Worked _____

Status: ☐ Current Employee ☐ Former Employee Separation Date _____

Has the employee returned to work? ☐ Yes ☐ No If Yes, date returned to work _____

Has or will the employee receive wages while disabled? ☐ Yes ☐ No

If Yes, give dates: from _____ to _____

Has the employee reported a work-related injury or occupational illness? ☐ Yes ☐ No

If Yes, have you files or do you intend to file a Workers' Compensation claim on behalf of the Claimant? ☐ Yes ☐ No

What days of the week does the employee normally work? _____

What is the employee's rate of pay and average hours worked per week? _____

Form Completed By _____ Date _____

Client Company _____

2739 U.S. Highway 19 N., Holiday, FL 34691
Telephone (727) 938-5562