MSU Human Resources
Dependent Disability Certification

Employee Name: ____
Last First Middle Initial

Employee ZPID: ____

Dependent Name: ____
Last First Middle Initial

Dependent Birthdate: ____

PHYSICIAN'S CERTIFICATION

In my judgment, ____ is
(dependent name)

__________ physically disabled __________ mentally disabled (check one)

to such a degree as to be incapable of any self-sustaining occupation.

Their condition, which has been diagnosed as ______________________________,

and the resulting incapacity has existed since ______________________________.

This disability is __________ permanent __________ temporary (check one)

If temporary, the prognosis for improvement to enable a self-sustaining occupation is:

____

______________________________ ______________________________
Physician's Signature **Date**

____
Business Address (street, city, zip code)

Please return this completed form to MSU Human Resources by emailing SolutionsCenter@hr.msu.edu, mail/drop-off in person to 1407 S. Harrison Rd., Suite 110, East Lansing, MI 48823 or fax to 517-432-3862.

MSU is an affirmative-action, equal-opportunity employer

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