CITY OF CANTON
CONTINUED DISABILITY APPLICATION

Name: _____ Dept.: _____ Union: _____

Sick Leave Effective Date: _____ Date of Return _____

In order to be considered, a medical statement from the healthcare provider must accompany this application. By signing below, the employee acknowledges that he/she will fully exhaust all sick leave accruals prior to approval for continuing disability benefits. The employee further acknowledges that there is a five-day waiting period for non-bargaining personnel and a three-day waiting period for bargaining personnel. Vacation may be used for the waiting period. This benefit is not applicable to the following bargaining units: Police (CPPA), Police Supervisors (FOP) or Fire (CPFFA).

EMPLOYEE SIGNATURE _____ **DATE** _____

FOR COMPLETION BY THE DEPARTMENT OF HUMAN RESOURCES

Sick Leave Balance: _____ Hire Date: _____ Length of Service _____ # Of Weeks Allowed: ___

Rate of Pay: _____ Waiting Period (Dates): _____ Disability Start Date _____

Are there any disciplinary actions to be considered? If so, provide comments_____

_____

Approved: ☐

Disapproved: ☐

_____
DIRECTOR OF HUMAN RESOURCES

_____
DATE

Approved: ☐

Disapproved: ☐

_____
APPOINTING AUTHORITY

DATE _____

LENGTH OF SERVICE	AVAILABLE WEEKS OF DISABILITY
6 months to 1 year	4
1 year to 5 years	15
5 years to 15 years	26
15 years and over	30

Revised: 1/6/2022