

**SICK LEAVE ADMINISTRATION  
APPLICATION FORM**



Date Received \_\_\_\_\_

SECTION 1 <i>(Please Print)</i>		EMPLOYEE'S STATEMENT	
<b>1. NAME</b>	FIRST	MIDDLE	LAST
<b>2. ADDRESS</b>			
_____		_____	
NUMBER		STREET	APT. #
_____		_____	
CITY OR TOWN		STATE	ZIP
<b>3. TELEPHONE (HOME AND/OR NUMBER WHERE YOU CAN BE REACHED)</b>		<b>4. EMPLOYEE NUMBER</b>	
HOME: _____		<b>5. OCCUPATION (Title)</b>	
(Area Code) (Number)		<b>6. SERVICE DATE (Date of Hire)</b>	
OTHER: _____		<b>8. WHILE ON DUTY?</b>	
(Area Code) (Number)		YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>7. DATE OF ILLNESS/INABILITY TO WORK</b>		<b>9. NATURE OF ILLNESS (IF INJURY, STATE HOW, WHEN, AND WHERE IT OCCURRED)</b>	
_____		_____	
_____		_____	
<b>10. I HEREBY CERTIFY THAT I WAS ILL AND NOT ABLE TO WORK DURING THE PERIOD FOR WHICH I AM CLAIMING SICK LEAVE ALLOWANCE; AND THAT THE FOREGOING STATEMENTS AND ANY ACCOMPANYING STATEMENTS ARE TRUE AND CORRECT. I AUTHORIZE ANY INSURANCE COMPANY, ORGANIZATION, EMPLOYER, HOSPITAL, PHYSICIAN, OR PHARMACIST TO RELEASE ANY INFORMATION REQUESTED WITH REGARD TO THIS CLAIM.</b>			
_____		_____	
(SIGNATURE)		(DATE CLAIM SIGNED)	
<b>SECTION 2</b>		<b>TO BE COMPLETED BY DEPARTMENT</b>	
AUTHORIZED SIGNATURE _____			
TITLE _____		DATE SIGNED _____	
RR MAILING ADDRESS _____		PHONE _____	

# PHYSICIAN'S STATEMENT

SLA-28

*For Completion by the Health Care Provider/Designee Only*

Rev.8/15

***The physician's statement must be filled in completely.***

1. CLAIMANT'S NAME	2. <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
3. DIAGNOSIS	4. ICD-9 DIAGNOSIS CODE(S):	
5. CLAIMANT'S SYMPTOMS  _____		
6. OPERATION INDICATED <input type="checkbox"/> YES <input type="checkbox"/> NO	6A. TYPE	6B. DATE
7. ENTER DATES FOR THE FOLLOWING:		
A. DATE OF CLAIMANT'S FIRST TREATMENT FOR THIS ILLNESS/CONDITION _____		
B. DATE OF CLAIMANT'S MOST RECENT TREATMENT FOR THIS ILLNESS/CONDITION _____		
C. FIRST DATE CLAIMANT WAS UNABLE TO WORK BECAUSE OF THIS ILLNESS/CONDITION _____		
D. DATE CLAIMANT WILL BE ABLE TO WORK _____		
E. IS CLAIMANT ABLE TO TRAVEL? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, WHEN _____		
F. PREGNANCY-APPROXIMATE DATE OF DELIVERY _____		
8. IN YOUR OPINION, IS THIS ILLNESS/CONDITION THE RESULT OF INJURY ARISING OUT OF AND IN THE COURSE OF EMPLOYMENT OR OCCUPATIONAL DISEASE? <input type="checkbox"/> YES <input type="checkbox"/> NO		
REMARKS: _____ _____ _____		
9. PHYSICIAN'S NAME ( <i>Please Print</i> )		License # or Stamp
9A. OFFICE ADDRESS	Number	Street
		City or Town
		ZIP Code
10. PHYSICIAN'S SIGNATURE	DATE	Phone Number

### IMPORTANT INSTRUCTIONS TO CLAIMANT

1. BE SURE TO SIGN AND DATE THIS FORM THE EMPLOYEE'S STATEMENT AND MAKE SURE ALL PORTIONS OF THE PHYSICIAN'S STATEMENT ARE COMPLETELY FILLED OUT.
2. THIS FORM MUST BE SUBMITTED TO YOUR SUPERVISOR WITHIN 3 DAYS AFTER YOU RETURN TO WORK. IF ILLNESS IS PROLONGED, THE SICK LEAVE FORM MAY BE FILED DURING THE PERIOD OF ABSENCE.
3. ANY PART OF THIS PAGE PREPARED BY OTHER THAN THE PHYSICIAN OR HIS/HER AUTHORIZED REPRESENTATIVE MAY RESULT IN DISCIPLINARY ACTION TO THE EMPLOYEE.
4. **BRS, IBEW, NCFE, SMW, TCU, UTU (TRACKWORKERS)** – SUBMIT THIS FORM IF YOU ARE OUT SICK FOR MORE THAN 2 DAYS OR ON YOUR THIRD AND SUBSEQUENT 2-DAY OCCURRENCE.
5. **IAM, UTU (CARMEN)** – SUBMIT THIS FORM IF YOU ARE OUT SICK FOR MORE THAN 2 DAYS.
6. **UTU (YARDMASTERS)** – SUBMIT THIS FORM ON YOUR THIRD AND SUBSEQUENT 2-DAY OCCURRENCE.
7. **TRAINMEN** – SUBMIT THIS FORM IF YOU ARE OUT SICK FOR MORE THAN 4 DAYS OR ON YOUR THIRD AND SUBSEQUENT 4-DAY OCCURRENCE.
8. **ENGINEERS** – SUBMIT THIS FORM IF YOU ARE OUT SICK FOR MORE THAN 4 DAYS OR ON YOUR THIRD AND SUBSEQUENT 4-DAY OCCURRENCE.

**PLEASE NOTE: ALTERED FORMS WILL NOT BE ACCEPTED.**