SLA-28

Rev. 11/17

SICK LEAVE ADMINISTRATION APPLICATION FORM

Date Received ___________

SECTION 1 (*Please Print*) **EMPLOYEE'S STATEMENT**

1. NAME FIRST MIDDLE LAST

2. ADDRESS

NUMBER STREET APT. #

CITY OR TOWN STATE ZIP

3. TELEPHONE (HOME AND/OR NUMBER WHERE YOU CAN BE REACHED)

HOME: ______________________________
(Area Code) (Number)

OTHER: ______________________________
(Area Code) (Number)

4. EMPLOYEE NUMBER

5. OCCUPATION (Title)

6. SERVICE DATE (Date of Hire)

7. DATE OF ILLNESS/INABILITY TO WORK

8. WHILE ON DUTY?
YES ☐ NO ☐

9. NATURE OF ILLNESS (IF INJURY, STATE HOW, WHEN, AND WHERE IT OCCURRED)

____

____

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.

______________________________ ______________________________

(SIGNATURE) (DATE CLAIM SIGNED)

SECTION 2 **TO BE COMPLETED BY DEPARTMENT**

AUTHORIZED SIGNATURE ______________________________

TITLE ______________________________ DATE SIGNED ______________________________

RR MAILING ADDRESS ______________________________ PHONE ______________________________

PHYSICIAN'S STATEMENT

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For Completion by the Health Care Provider/Designee Only

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

1. CLAIMANT'S NAME	2. ☐ MALE ☐ FEMALE
3. DIAGNOSIS	4. ICD-9/ICD-10 DIAGNOSIS CODE(S):

5. CLAIMANT'S SYMPTOMS____

____

6. OPERATION INDICATED ☐ YES ☐ 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? ☐ YES ☐ 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? ☐ YES IF YES - COMPLETE BELOW:

A: PROCEDURES USED/RECOMMENDED: ______________________

B: MEDICATIONS USED/RECOMMENDED: ______________________

C: THERAPY USED/RECOMMENDED: ___ ______________________

☐ NO REMARKS:

9. PHYSICIAN'S NAME (*Please Print*) 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 THE EMPLOYEE'S STATEMENT, AND MAKE SURE THAT ALL PORTIONS OF BOTH THE EMPLOYEE'S STATEMENT AND THE PHYSICIAN'S STATEMENT ARE COMPLETED.
2. ANY PART OF THIS PAGE (PHYSICIAN'S STATEMENT), PREPARED BY A PERSON OTHER THAN THE PHYSICIAN OR HIS/HER AUTHORIZED REPRESENTATIVE, MAY RESULT IN DISCIPLINARY ACTION TO THE EMPLOYEE.
3. AN EMPLOYEE MUST COMPLETE AND SUBMIT THIS FORM CONSISTENT WITH THE REQUIREMENTS OF HIS/HER DEPARTMENT'S RULES AND PROCEDURES, LIRR CORPORATE POLICIES AND PROCEDURES, AND APPLICABLE COLLECTIVE BARGAINING AGREEMENT (CBA).
4. THIS FORM IS NOT REQUIRED FOR AN APPROVED FMLA RELATED ILLNESS/CONDITION.

PLEASE NOTE: ALTERED FORMS WILL NOT BE ACCEPTED