

DEPARTMENT _____ RC#/DIVISION _____ Date _____ 20 _____

Name _____ Title _____ RDO _____ Pass No. _____

A.M. A.M.

Absent from _____, 20 _____, _____ P.M. to _____, 20 _____, _____ P.M. inclusive for a total of _____ working days.

I was unfit for work on account of illness during this period and request a paid/unpaid (circle as appropriate) leave of absence because (state nature of disability).

Did this illness arise as a result of a service connected incident? _____ Yes/No

Name of treating physician _____ Address _____ Telephone No. _____

(print)

(print)

Received: _____ Pass No. _____ Date _____

Employee's Signature

Supervisor

Failure to submit this application within three (3) days after returning to work will result in loss of pay for the period in question and may also result in disciplinary action against the employee. Where absence is for more than two (2) days, this certification must be completely filled out by the attending physician before sick leave with pay will be approved. OA employees should be guided by the applicable section of the collective bargaining agreement to determine when a physician's certification is required.

Do Not Write Below This Line

DOCTOR'S CERTIFICATION (For Doctor's Use Only)

I hereby certify that _____ was treated or evaluated by me on the date/s indicated for an illness noted below:

Employee's Name

Dates of treatment: Home _____ Office _____ Hospital _____

DIAGNOSIS/OBJECTIVE FINDINGS _____

TREATMENT/PROGNOSIS _____
AND EXPECTED DATE _____
OF RETURN _____

I further certify that this illness so incapacitated this employee that he/she was incapable of performing his/her duties during the period from: _____ to _____, and that the information in this section, which will be used for payment purposes, is truthful.

Physician Stamp

Date _____

Physician's Signature/Tax ID No.

Departmental Report

Departmental Referral to Absentee Control

REASON FOR REFERRAL
(check box if appropriate)

Remarks _____

- Review for incomplete certification
- Review for fraudulent/altered certification
- Review-is period of absences consistent with illness?
- Other _____

Reviewed by _____ Name _____ Date _____

LAST 12 MONTH USAGE REPORT

Substantiated
Instances

Unsubstantiated
Instances

Prior to
Request

Post
Request

ACTION ON APPLICATION

Approved Paid _____ Days _____ Hours

Unpaid _____ Days _____ Hours

Disapproved _____ Days _____ Hours

Sick Leave Control List _____ Yes/No

Signature _____
Department Head or Designee

Reason for Disapproval: _____

Signature _____