NORTHERN INDIANA PUBLIC SERVICE COMPANY

SICK LEAVE CLAIM FORM

TO BE COMPLETED BY EMPLOYEE – For temporary exceptions related to COVID-19 agreements, Employee Section below must be completed and submitted.

NAME:	Home Phone:	Hire Date:	Employee ID Number:
Job Classification:	Work Phone:	Location/Dept:	

Last Day worked:	First day of Sick Leave:	Returned to Work on:
Illness ☐ Injury ☐	Is Illness/injury a result of your occupation?	No ☐ Yes ☐

NATURE OF ILLNESS/INJURY (if injury, describe when, where and how it occurred):

I affirm that the information contained on this form is true and correct:

Employee Signature: _____ Date: _____

TO BE COMPLTED BY PHYSICIAN (Incomplete forms will be returned to the employee and no benefits will be paid until a completed form is received)

IS THIS EMPLOYEE UNABLE TO WORK DUE TO THIS ILLNESS OR INJURY: No ☐ Yes ☐

DIAGNOSIS OR NATURE OF ILLNESS/INJURY:

DATE ILLNESS/INJURY BEGAN:	DATE(S)EXAMINED FOR THIS CLAIM:

In your medical opinion, did the illness/injury or symptoms diagnosed from this examination prevent the employee from working beginning with the first day of sick leave, shown in the box above, prior to this examination? No ☐ Yes ☐

Comments:_____

_____

Was Hospitalization Required? No □ Yes □ If yes, Admittance date: Discharge date:	Was Medication Prescribed? No □ Yes □ Was surgery required: No □ Yes □ If yes, date of surgery:

☐ THE EMPLOYEE **IS NOT RELEASED** TO RETURN TO WORK ESTIMATED DATE OF RETURN:

☐ THE EMPLOYEE **IS RELEASED** TO RETURN TO WORK RETURN TO WORK DATE:

LIST LIMITATIONS, if any (No Diagnostic Information): _____

_____

_____

Expected Duration of Limitations:

If re-exam is necessary, on what date?

As a result of your authorization of absence from work, employer may incur a liability for Sick Leave Benefits. This form may only be signed by a Licensed Physician, Licensed Nurse Practitioner, Physician Assistant, or Oral Surgeon.

Signature: _____ Specialty/Practice: _____

Print Name: _____ Address: _____

Date Signed: _____ Phone: _____

Forms can be submitted to Sick Leave Claim Administrator at leaveteam@nisource.com or fax to (844)229-3822