NORTHERN INDIANA PUBLIC SERVICE COMPANY

SICK LEAVE CLAIM FORM

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| NAME: | HomePhone: | HireDate: | EmployeeID Number: |
| JobClassification: | WorkPhone: | 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): |
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|  |
| 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: |
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|  |
| 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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

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