NORTHERN INDIANA PUBLIC SERVICE COMPANY

SICK LEAVE CLAIM FORM

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| 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: | | | | | | |
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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**](mailto:leaveteam@nisource.com) **or fax to (844)229-3822**