SICK LEAVE WITHDRAWAL REQUEST

Please complete and attach your physician's signed statement and any other documentation required as per the current CSEA 9200 Collective Bargaining agreement, Article VII, Section 6

(Must submit Originals only)

Name: _____ **Social Security #** _____

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Primary Phone:** _____

Department _____ **Date of Hire:** _____/_____/_____

Work Location_____ **Work Phone:** _____

Physician: _____ **Phone#:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Reason for Request: _____

Please provide personal Email address: _____

Have you requested Extended Sick Leave (ESL)? YES [ ] or NO [ ]

If Yes, Date: _____ /_____/_____

Was your Extended Sick Leave APPROVED [ ] OR DENIED [ ]

The Sick Leave Bank Committee has my permission to review my time and attendance records or any items from my personnel file that may have an impact on my application, and contact my attending Physician, if necessary

Signature: _____ Date: _____

To Attending Physician:

The Information requested on this form will be used in a confidential manner as a basis for determining whether the employee is entitled to additional sick leave pay. Please answer ALL questions to prevent processing delays.

Section "A" (TO BE COMPLETED BY EMPLOYEE)

Employee's Name_____

Employee's Address_____

_____

Section "B" (ATTENDING PHYSICIAN REPORT / DOCTOR'S NOTE)

Diagnosis: (If surgery has been performed, please describe and give dates)

_____

_____

_____

_____

Medical Prognosis:

1.When did you first treat the employee for his/her illness/disability? _____/_____/_____

2.When did you last examine the employee: _____/_____/_____

3.Please give an ESTIMATED date when the employee will be able to work: _____/____/____

4.Has the employees condition: **Improved [ ] or Unchanged [ ]**

5.Date employee ceased work because of illness/disability: _____/_____/____

6.Is the employee presently disabled and unable to perform his/her regular duties?

Yes [ ] or No [ ]

7.Is the employee unable to perform any duties? [ ] Yes or [ ] No

8. Is this a job related injury or illness? **Yes [ ] or No [ ]**

If more information is needed, you may reach me between the hours of _____&_____ at the following Phone Number#_____

MD Signature_____ Date: _____