



Long Island Rail Road

ENGINEERS

SICK LEAVE ADMINISTRATION FORM APPLICATION for SICK LEAVE DUE to ILLNESS or DISABILITY

DATE RECEIVED _____

CLAIM NUMBER _____

SECTION 1 <small>(Please Print)</small>		CLAIMANT'S STATEMENT		*See Reverse Side for Instructions																																									
1 NAME FIRST MIDDLE LAST		4 EMPLOYEE NUMBER																																											
2 ADDRESS		5 OCCUPATION		JOB # RELIEF DAYS																																									
NUMBER STREET		6. SERVICE DATE																																											
CITY OR TOWN STATE ZIP		7 AGE																																											
3 TELEPHONE (Home and/or number where you can be reached)		8 SEX																																											
HOME Area Code _____ Number _____		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE																																											
OTHER Area Code _____ Number _____																																													
9 NATURE OF ILLNESS OR DISABILITY (If injury, state how, when and where it occurred)																																													
10 DATE OF DISABILITY Month Day Year			11 WHILE ON DUTY?																																										
			<input type="checkbox"/> YES <input type="checkbox"/> NO																																										
12 I HAVE READ THE ABOVE, AND HEREBY CERTIFY THAT I WAS DISABLED DURING THE PERIOD FOR WHICH I AM CLAIMING SICK LEAVE ALLOWANCE, AND THAT THE FOREGOING STATEMENTS, INCLUDING ANY ACCOMPANYING STATEMENTS, ARE TO THE BEST OF MY KNOWLEDGE TRUE AND COMPLETE.																																													
(SIGNATURE)			(CLAIM SIGNED ON)																																										
SECTION 2 <small>(Please Print)</small>		DEPARTMENT REPORT		EMPLOYEE #																																									
1 EMPLOYEE'S NAME (As indicated on pay check) FIRST INITIAL MIDDLE INITIAL LAST NAME																																													
2 ALL INFORMATION GIVEN BY EMPLOYEE IN SECTION 1 IS TO BE VERIFIED IF THE INFORMATION IS INCORRECT, ENTER THE CORRECT DATA AND INITIAL CHANGE																																													
3. WAS THE EMPLOYEE ACTIVELY IN YOUR EMPLOY WHEN THE ILLNESS OR DISABILITY OCCURRED?																																													
<input type="checkbox"/> YES <input type="checkbox"/> NO (A) IF "NO," EXPLAIN _____																																													
4 DATE EMPLOYEE LAST WORKED		MONTH DAY YEAR																																											
4a LAST DAY EMPLOYEE RECEIVED REGULAR WAGES		MONTH DAY YEAR																																											
4b DATE AND TIME EMPLOYEE RETURNED TO WORK		MONTH DAY YEAR		TIME AM PM																																									
5a INDICATE THE FOLLOWING INFORMATION AND SUPPLY THE RELIEF DAYS FOR CLAIMANT				5b PERSONNEL INFORMATION																																									
<table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th>DAY OF WEEK</th> <th>DATE</th> <th>S.T. HOURS</th> <th>O.T. HOURS</th> <th>HOL. HOURS</th> </tr> </thead> <tbody> <tr><td>WEDNESDAY</td><td></td><td></td><td></td><td></td></tr> <tr><td>THURSDAY</td><td></td><td></td><td></td><td></td></tr> <tr><td>FRIDAY</td><td></td><td></td><td></td><td></td></tr> <tr><td>SATURDAY</td><td></td><td></td><td></td><td></td></tr> <tr><td>SUNDAY</td><td></td><td></td><td></td><td></td></tr> <tr><td>MONDAY</td><td></td><td></td><td></td><td></td></tr> <tr><td>TUESDAY</td><td></td><td></td><td></td><td></td></tr> </tbody> </table>				DAY OF WEEK	DATE	S.T. HOURS	O.T. HOURS	HOL. HOURS	WEDNESDAY					THURSDAY					FRIDAY					SATURDAY					SUNDAY					MONDAY					TUESDAY					PAYROLL CREW # _____	
DAY OF WEEK	DATE	S.T. HOURS	O.T. HOURS	HOL. HOURS																																									
WEDNESDAY																																													
THURSDAY																																													
FRIDAY																																													
SATURDAY																																													
SUNDAY																																													
MONDAY																																													
TUESDAY																																													
				DIV _____ 4 _____ ICC _____																																									
				DEPT _____ 98 _____ RATE CODE _____																																									
				RATE OF PAY _____ PER HOUR																																									
				5c WAS THE EMPLOYEE'S JOB COVERED DURING THE PERIOD FOR WHICH THE CLAIM IS BEING MADE?																																									
				<input type="checkbox"/> YES <input type="checkbox"/> NO																																									
				IF YES, INDICATE THE NUMBER OF DAYS AND WHETHER IT WAS COVERED AT THE STRAIGHT TIME RATE _____																																									
				AND/OR OVERTIME RATE _____																																									
6 EMPLOYEE'S UNION AFFILIATION		5d DIFFERENTIAL RATE: HRLY \$ _____ DAILY \$ _____ MO \$ _____																																											
BROTHERHOOD OF LOCOMOTIVE ENGINEERS		NUMBER OF HOURS _____																																											
7 WAS THE DISABILITY DUE TO AN "ON DUTY" ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO																																													
SECTION 3																																													
AUTHORIZED SIGNATURE _____			TITLE ABSENCE CONTROL EXAMINER																																										
DATE SIGNED _____			PHONE EXTENSION 311																																										

ANY PART OF THIS PAGE PREPARED BY OTHER THAN THE DOCTOR OR HIS REPRESENTATIVE WILL RESULT IN A DENIAL OF BENEFITS TO THE EMPLOYEE.

DOCTOR'S STATEMENT

The doctor's statement must be filled in completely. For Item 6d, give approximate date. Make some estimate. Delay in sick leave payment will be avoided if all information is supplied as requested.

1. CLAIMANT'S NAME		2. AGE	3. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE																		
4. DIAGNOSIS																					
4a. CLAIMANT'S SYMPTOMS																					
4b. OBJECTIVE FINDINGS																					
5. OPERATION INDICATED? <input type="checkbox"/> YES <input type="checkbox"/> NO	5a. TYPE	5b. DATE																			
6. ENTER DATES FOR THE FOLLOWING																					
A. DATE OF YOUR FIRST TREATMENT FOR THIS DISABILITY	B. DATE OF YOUR MOST RECENT TREATMENT FOR THIS DISABILITY	C. DATE CLAIMANT WAS UNABLE TO WORK BECAUSE OF THIS DISABILITY	D. DATE CLAIMANT WILL BE ABLE TO PERFORM USUAL WORK																		
E. DATE CLAIMANT WILL BE ABLE TO PERFORM ANY WORK	<table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th style="width:33%;">MONTH</th> <th style="width:33%;">DAY</th> <th style="width:33%;">YEAR</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>			MONTH	DAY	YEAR															
MONTH	DAY	YEAR																			
7. IN YOUR OPINION, IS THIS DISABILITY THE RESULT OF INJURY ARISING OUT OF AND IN THE COURSE OF EMPLOYMENT OR OCCUPATIONAL DISEASE? <input type="checkbox"/> YES <input type="checkbox"/> NO																					
REMARKS _____																					
8. PHYSICIAN'S NAME (Please Print)			WCB RATING CODE																		
8a. OFFICE ADDRESS	Number	Street	City or Town Zip Code																		
9. DATE	10. PHYSICIAN'S SIGNATURE																				

IMPORTANT INSTRUCTIONS TO CLAIMANT

1. USE THIS FORM ONLY IF YOU BECOME SICK OR DISABLED WHILE EMPLOYED
2. BE SURE TO SIGN AND DATE CLAIM THIS WILL AVOID DELAY IN PAYMENT
3. IF THE CLAIM IS FOR MORE THAN FOUR (4) DAYS HAVE YOUR MEDICAL DOCTOR COMPLETE THE ABOVE STATEMENT BEFORE SUBMITTING THE APPLICATION
4. THE APPLICATION MUST BE SUBMITTED TO YOUR SUPERVISOR WITHIN THREE (3) DAYS AFTER YOU RETURN TO WORK. IF ILLNESS OR DISABILITY IS PROLONGED, THE SICK LEAVE APPLICATION MAY BE FILED DURING THE PERIOD OF ABSENCE
5. DOCTOR'S NOTE IS REQUIRED FOR A THIRD AND SUBSEQUENT SICK LEAVE ABSENCE CONSISTING OF A FOUR-DAY PERIOD IN A CALENDAR YEAR
6. A SICK LEAVE FORM MUST BE SUBMITTED FOR ALL ABSENCES DUE TO ILLNESS OR INJURY.
7. ANY PART OF THIS PAGE PREPARED BY OTHER THAN THE DOCTOR OR HIS REPRESENTATIVE WILL RESULT IN A DENIAL OF BENEFITS TO THE EMPLOYEE