



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

Date Received _____
 Claim Number _____

SECTION 1 (Please Print)			
EMPLOYEE'S STATEMENT			
1. NAME	FIRST	MIDDLE	LAST
2. ADDRESS			
_____		_____	
NUMBER		STREET	APT. #
_____		_____	
CITY OR TOWN		STATE	ZIP
3. TELEPHONE (HOME AND/OR NUMBER WHERE YOU CAN BE REACHED)		4. EMPLOYEE NUMBER	
HOME: _____		_____	
(Area Code) (Number)		5. OCCUPATION	
OTHER: _____		6. SERVICE DATE	
(Area Code) (Number)		_____	
7. DATE OF DISABILITY		8. WHILE ON DUTY?	
_____		YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. NATURE OF ILLNESS OR DISABILITY (IF INJURY, STATE HOW, WHEN, AND WHERE IT OCCURRED, OTHERWISE CLAIM WILL BE DENIED)			

10. I 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 TRUE AND CORRECT.			
I AUTHORIZE ANY INSURANCE COMPANY, ORGANIZATION, EMPLOYER, HOSPITAL, PHYSICIAN, OR PHARMACIST TO RELEASE ANY INFORMATION REQUESTED WITH REGARD TO THIS CLAIM			
_____		_____	
(SIGNATURE)		(DATE CLAIM SIGNED)	
SECTION 2			
SICK LEAVE INFORMATION ON THIS FORM WAS OR WILL BE VERIFIED TO THE INFORMATION SUBMITTED THROUGH PAYROLL FOR THE SAME PERIOD OF ILLNESS.			
AUTHORIZED SIGNATURE _____			
TITLE _____		DATE SIGNED _____	
RR MAILING ADDRESS _____		PHONE _____	

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.

1. CLAIMANT'S NAME		2. <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
1. DIAGNOSIS		2. ICD-9 DIAGNOSIS CODE (S):	
3. CLAIMANT'S SYMPTOMS _____			
4. OPERATION INDICATED <input type="checkbox"/> YES <input type="checkbox"/> NO	6A. TYPE	6B. DATE	
5. 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 WORK _____			
E. IS CLAIMANT ABLE TO TRAVEL? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, WHEN _____			
F. PREGNANCY-APPROXIMATE DATE OF DELIVERY _____			
6. 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: _____ _____ _____			
9. PHYSICIAN'S NAME (<i>Please Print</i>)		WCB RATING CODE	
9A. OFFICE ADDRESS	Number	Street	City or Town ZIP Code
10. PHYSICIAN'S SIGNATURE		DATE	

IMPORTANT INSTRUCTIONS TO CLAIMANT

1. USE THIS FORM ONLY IF YOU BECOME SICK FOR MORE THAN 4 DAYS OR ON YOUR 3RD FOUR DAY OCCURRENCE.
2. BE SURE TO SIGN AND DATE CLAIM, AND MAKE SURE ALL PORTIONS OF DOCTOR'S STATEMENT ARE COMPLETELY FILLED OUT.
3. 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 ABSENSE.
4. ANY PART OF THIS PAGE PREPARED BY OTHER THAN THE DOCTOR OR HIS REPRESENTATIVE MAY RESULT IN DISCIPLINARY ACTION TO THE EMPLOYEE.