

Application for Leave of Absence Due to Illness

DEPARTMENT _____ RC#/DIVISION _____ Date _____ 20 _____

Name _____ Title _____ RDO _____ Pass No. _____

Absent from _____, 20 _____, _____ A.M. to _____, 20 _____, _____ A.M. working P.M. inclusive for a total of _____ days.

I was unfit for work on account of illness during this period and request a paid/unpaid (circle as appropriate) leave of absence because (state nature of disability):

Did this disability arise as a result of a service connected incident? _____ Yes/No

Name of treating physician _____ Address _____ Telephone No. _____
(print) (print)

Received: _____ Pass No. _____ Date _____
Employee's Signature Supervisor

Failure to submit this application within three (3) days after returning to work will result in loss of pay for the period in question and may also result in disciplinary action against the employee. Where absence is for more than two (2) days, this certification must be completely filled out by the attending physician before sick leave with pay will be approved. OA employees should be guided by the applicable section of the collective bargaining agreement to determine when a physician's certification is required.

DOCTOR'S CERTIFICATION

I hereby certify that _____ was treated by me on the date/s and for illness noted below:
Employee's Name

Dates of treatment: Home _____ Office _____ Hospital _____

DIAGNOSIS/OBJECTIVE FINDINGS _____

TREATMENT/PROGNOSIS AND EXPECTED DATE OF RETURN _____

I further certify that this illness so incapacitated this employee that he/she was incapable of performing his/her duties during the period from: _____ to _____, and that the information in this section, which will be used for payment purposes, is truthful.

Physician Stamp

Date _____
Physician's Signature/Tax ID No. _____

DEPARTMENTAL REPORT

DEPARTMENTAL REFERRAL TO ABSENTEE CONTROL

REASON FOR REFERRAL
(check box if appropriate)

Remarks _____

- Review for incomplete certification
- Review for fraudulent/altered certification
- Review - is period of absence consistent with illness? Reviewed by _____
- Other: _____

Name _____ Date _____

LAST 12 MONTH USAGE REPORT

SICK LEAVE BANK BALANCE

ACTION ON APPLICATION

Substantiated Instances Unsubstantiated Instances

Prior to Request Post Request

Approved Paid _____ Days _____ Hours

Unpaid _____ Days _____ Hours

Disapproved _____ Days _____ Hours

Sick Leave Control List _____ Yes/No Signature _____

Department Head or Designee

Reason for Disapproval: _____

Signature _____