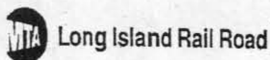
SLA-28
Rev. 1/04



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

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)

HOME: ______________________________
(Area Code) (Number)

OTHER: ______________________________
(Area Code) (Number)

4. EMPLOYEE NUMBER

5. OCCUPATION

6. SERVICE DATE

7. DATE OF DISABILITY

8. WHILE ON DUTY?

YES ☐ NO ☐

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 ______________________

SLA-28
Rev. 1/04

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. ☐ MALE ☐ FEMALE

1. DIAGNOSIS

2. ICD-9 DIAGNOSIS CODE (S):

3. CLAIMANT'S SYMPTOMS

____

____

4. OPERATION INDICATED ☐ YES ☐ 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? ☐YES ☐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? ☐ YES ☐ NO

REMARKS:____

____

____

9. PHYSICIAN'S NAME (*Please Print*)

WCB RATING CODE

9A. OFFICE ADDRESS Number Street City or Town ZIP Code

10. PHYSICIAN'S SIGNATURE

DATE

IMPORTANT INSTRUCTIONS TO CLAIMANT

1. BRS. IBEW. NCFO. SMW. TCU. UTU(TRACKWORKERS) - USE THIS FORM IF YOU BECOME SICK FOR MORE THAN 2 DAYS OR ON YOUR 3RD TWO DAY OCCURRENCE.
2. IAM. UTU(CARMEN) – USE THIS FORM IF YOU BECOME SICK FOR MORE THAN 2 DAYS.
3. UTU(YARDMASTERS) – USE THIS FORM ON YOUR THIRD TWO DAY OCCURRENCE.
4. BE SURE TO SIGN AND DATE CLAIM. AND MAKE SURE ALL PORTIONS OF DOCTOR'S STATEMENT ARE COMPLETLY FILLED OUT.
5. 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.
6. ANY PART OF THIS PAGE PREPARED BY OTHER THAN THE DOCTOR OR HIS REPRESENTATIVE MAY RESULT IN DISCIPLINARY ACTION TO THE EMPLOYEE.