



**SICK LEAVE ADMINISTRATION
APPLICATION FORM**

Date Received _____

SECTION 1 <i>(Please Print)</i>		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 (Title)	
OTHER: _____		6. SERVICE DATE (Date of Hire)	
(Area Code) (Number)			
7. DATE OF ILLNESS/INABILITY TO WORK		8. WHILE ON DUTY?	
		YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. NATURE OF ILLNESS (IF INJURY, STATE HOW, WHEN, AND WHERE IT OCCURRED)			

10. I HEREBY CERTIFY THAT I WAS ILL AND NOT ABLE TO WORK DURING THE PERIOD FOR WHICH I AM CLAIMING SICK LEAVE ALLOWANCE; AND THAT THE FOREGOING STATEMENTS AND 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		TO BE COMPLETED BY DEPARTMENT	
AUTHORIZED SIGNATURE _____			
TITLE _____		DATE SIGNED _____	
RR MAILING ADDRESS _____		PHONE _____	

PHYSICIAN'S STATEMENT

SLA-28

For Completion by the Health Care Provider/Designee Only

Rev. 11/17

The physician's statement must be filled in completely.

1. CLAIMANT'S NAME	2. <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
3. DIAGNOSIS	4. ICD-9/ICD-10 DIAGNOSIS CODE(S):

5. CLAIMANT'S SYMPTOMS _____

6. OPERATION INDICATED YES NO 6A. TYPE 6B. DATE

7. ENTER DATES FOR THE FOLLOWING:

A. DATE OF CLAIMANT'S FIRST TREATMENT FOR THIS ILLNESS/CONDITION _____

B. DATE OF CLAIMANT'S MOST RECENT TREATMENT FOR THIS ILLNESS/CONDITION _____

C. FIRST DATE CLAIMANT WAS UNABLE TO WORK BECAUSE OF THIS ILLNESS/CONDITION _____

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 _____

8. IN YOUR OPINION, IS THIS ILLNESS/CONDITION THE RESULT OF INJURY ARISING OUT OF AND IN THE COURSE OF EMPLOYMENT OR OCCUPATIONAL DISEASE? YES IF YES - COMPLETE BELOW:

A: PROCEDURES USED/RECOMMENDED: _____

B: MEDICATIONS USED/RECOMMENDED: _____

C: THERAPY USED/RECOMMENDED: _____

NO REMARKS: _____

9. PHYSICIAN'S NAME (Please Print) _____ License # or Stamp _____

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

10. PHYSICIAN'S SIGNATURE _____ DATE _____ Phone Number _____

IMPORTANT INSTRUCTIONS TO CLAIMANT

1. BE SURE TO SIGN AND DATE THE EMPLOYEE'S STATEMENT, AND MAKE SURE THAT ALL PORTIONS OF BOTH THE EMPLOYEE'S STATEMENT AND THE PHYSICIAN'S STATEMENT ARE COMPLETED.
2. ANY PART OF THIS PAGE (PHYSICIAN'S STATEMENT), PREPARED BY A PERSON OTHER THAN THE PHYSICIAN OR HIS/HER AUTHORIZED REPRESENTATIVE, MAY RESULT IN DISCIPLINARY ACTION TO THE EMPLOYEE.
3. AN EMPLOYEE MUST COMPLETE AND SUBMIT THIS FORM CONSISTENT WITH THE REQUIREMENTS OF HIS/HER DEPARTMENT'S RULES AND PROCEDURES, LIRR CORPORATE POLICIES AND PROCEDURES, AND APPLICABLE COLLECTIVE BARGAINING AGREEMENT (CBA).
4. THIS FORM IS NOT REQUIRED FOR AN APPROVED FMLA RELATED ILLNESS/CONDITION.

PLEASE NOTE: ALTERED FORMS WILL NOT BE ACCEPTED