SLA-28

Rev. 11/17

Long Island Rail Road

SICK LEAVE ADMINISTRATION APPLICATION FORM

Date Received_____

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 (Title)

6. SERVICE DATE (Date of Hire)

7. DATE OF ILLNESS/INABILITY TO WORK

8. WHILE ON DUTY?
YES ☐ **NO** ☐

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

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For Completion by the Health Care Provider/Designee Only

The physician's statement must be filled in completely.

1. CLAIMANT'S NAME	**2.** ☐ **MALE** ☐ **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