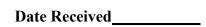
Rev. 11/17

## SICK LEAVE ADMINISTRATION APPLICATION FORM



M	Long	Island	Rail	Road
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SECTION 1 (Pleas	se Print)EMPI	LOYEE'S STATEMEN	T			
1. NAME	FIRST	MIDDLE	LAST			
2. ADDRESS						
	NUMBER	STREET	<b>APT.</b> #			
	CITY OR TOWN		STATE	ZIP		
3. TELEPHONE CAN BE REAC	(HOME AND/OR NUMBER V CHED)	WHERE YOU 4.	EMPLOYEE NUMBER			
HOME:		5	OCCUPATION (Title)			
	(Area Code) (Number)		OCCUPATION (Title)			
OTHER:		6.	SERVICE DATE (Date	of Hire)		
	(Area Code) (Number)					
7. DATE OF ILL	NESS/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.						
(SIGNATUR			(DATE CLAIM S	IGNED)		
SECTION 2	TO BI	E COMPLETED BY D	EPARTMENT			
AUTHORIZED SI	GNATURE					
TITLE		DATE SIGNED				
RR MAILING AD	PHONE					

## PHYSICIAN'S STATEMENT

SLA-28

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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.				
3.	DIAGNOSIS	4. DIAGNOSIS CODE(S):				
5.	CLAIMANT'S SYMPTOMS					
6.	OPERATION INDICATED ☐ YES ☐ NO 6A. TYPE	6B. DATE				
7. E	NTER DATES FOR THE FOLLOWING:					
A.	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.	D. DATE CLAIMANT WILL BE ABLE TO WORK					
E.	E. IS CLAIMANT ABLE TO TRAVEL?					
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. Pl	PHYSICIAN'S NAME (Please Print)  License # or Stamp					
9A. (	OFFICE ADDRESS Number Street City or To	wn ZIP Code				
10. P	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