



**SICK LEAVE ADMINISTRATION  
APPLICATION FORM**

Date Received \_\_\_\_\_

SECTION 1 (Please Print)		EMPLOYEE'S STATEMENT	
<b>1. NAME</b>	<b>FIRST</b>	<b>MIDDLE</b>	<b>LAST</b>
<b>2. ADDRESS</b>			
_____			
NUMBER		STREET	APT. #
_____			
CITY OR TOWN		STATE	ZIP
<b>3. TELEPHONE (HOME AND/OR NUMBER WHERE YOU CAN BE REACHED)</b>		<b>4. EMPLOYEE NUMBER</b>	
HOME: _____			
(Area Code) (Number)		<b>5. OCCUPATION (Title)</b>	
OTHER: _____		<b>6. SERVICE DATE (Date of Hire)</b>	
(Area Code) (Number)			
<b>7. DATE OF ILLNESS/INABILITY TO WORK</b>		<b>8. WHILE ON DUTY?</b>	
		YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>9. NATURE OF ILLNESS (IF INJURY, STATE HOW, WHEN, AND WHERE IT OCCURRED)</b>			
_____			
_____			
<b>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.</b>			
_____		_____	
(SIGNATURE)		(DATE CLAIM SIGNED)	
<b>SECTION 2</b>		<b>TO BE COMPLETED BY DEPARTMENT</b>	
<b>AUTHORIZED SIGNATURE</b> _____			
<b>TITLE</b> _____		<b>DATE SIGNED</b> _____	
<b>RR MAILING ADDRESS</b> _____		<b>PHONE</b> _____	

# 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 <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES IF YES - COMPLETE BELOW:			
A: PROCEDURES USED/RECOMMENDED: _____			
B: MEDICATIONS USED/RECOMMENDED: _____			
C: THERAPY USED/RECOMMENDED: _____			
<input type="checkbox"/> 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
<b>IMPORTANT INSTRUCTIONS TO CLAIMANT</b>			
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.			
<b>PLEASE NOTE: ALTERED FORMS WILL NOT BE ACCEPTED</b>			