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 _______________________

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**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 COMPLETELY 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.**