SICK LEAVE REQUEST FORM

PHYSICIAN STATEMENT(Please complete all blanks) **Date** _____

Name _____ has been under my professional care from _____ to _____.

Injury or first symptoms appeared on _____

Diagnosis or current condition of patient _____

_____

Expected treatment duration _____ Return to work date _____

Physicians Name _____ Address _____

Phone Number _____ Signature _____

EMPLOYEE STATEMENT

Name _____ Payroll Number _____ Division _____

Address _____ Phone _____

Last Day Worked _____ Return to Work _____ Regular Days Off _____

Indicate if you were out of work due to: (check the one that applies)

Off-the-Job ( ) Illness ( ) Accident ( ) Motor Vehicle ( ) Yes ( ) No

On-the-Job ( ) Illness ( ) Accident ( ) Motor Vehicle ( ) Yes ( ) No

Signature _____ Date _____

FOR COMPLETION BY PERSONNEL DEPARTMENT

Hourly Wage _____ First Unable to Work _____

First 2 Working Days _____ Payable from _____

DATES	WEEKLY WAGE	LESS DISABILITY/COMP PAID	BBF	HOURS PAID