SLA-28

Rev.8/15

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

SLA-28

For Completion by the Health Care Provider/Designee Only

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The physician's statement must be filled in completely.

1. CLAIMANT'S NAME	**2.** ☐ **MALE** ☐ **FEMALE**
3. DIAGNOSIS	**4. ICD-9 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** ☐ **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 THIS FORMTHE EMPLOYEE'S STATEMENT AND MAKE SURE ALL PORTIONS OF THE PHYSICIAN'S STATEMENT ARE COMPLETELY FILLED OUT.**
2. **THIS FORM MUST BE SUBMITTED TO YOUR SUPERVISOR WITHIN 3 DAYS AFTER YOU RETURN TO WORK. IF ILLNESS IS PROLONGED, THE SICK LEAVE FORM MAY BE FILED DURING THE PERIOD OF ABSENCE.**
3. **ANY PART OF THIS PAGE PREPARED BY OTHER THAN THE PHYSICIAN OR HIS/HER AUTHORIZED REPRESENTATIVE MAY RESULT IN DISCIPLINARY ACTION TO THE EMPLOYEE.**
4. **BRS, IBEW, NCFO, SMW, TCU, UTU (TRACKWORKERS)** – SUBMIT THIS FORM IF YOU ARE OUT SICK FOR MORE THAN 2 DAYS OR ON YOUR THIRD AND SUBSEQUENT 2-DAY OCCURRENCE.
5. **IAM, UTU (CARMEN)** – SUBMIT THIS FORM IF YOU ARE OUT SICK FOR MORE THAN 2 DAYS.
6. **UTU (YARDMASTERS)** – SUBMIT THIS FORM ON YOUR THIRD AND SUBSEQUENT 2-DAY OCCURRENCE.
7. **TRAINMEN** – SUBMIT THIS FORM IF YOU ARE OUT SICK FOR MORE THAN 4 DAYS OR ON YOUR THIRD AND SUBSEQUENT 4-DAY OCCURRENCE.
8. **ENGINEERS** – SUBMIT THIS FORM IF YOU ARE OUT SICK FOR MORE THAN 4 DAYS OR ON YOUR THIRD AND SUBSEQUENT 4-DAY OCCURRENCE.

PLEASE NOTE: ALTERED FORMS WILL NOT BE ACCEPTED.