



DEPARTMENT \_\_\_\_\_ RC#/DIVISION \_\_\_\_\_ Date \_\_\_\_\_ 20 \_\_\_\_\_

Name \_\_\_\_\_ Title \_\_\_\_\_ RDO \_\_\_\_\_ Pass No. \_\_\_\_\_

A.M. A.M.  
Absent from \_\_\_\_\_, 20 \_\_\_\_\_, \_\_\_\_\_ P.M. to \_\_\_\_\_, 20 \_\_\_\_\_, \_\_\_\_\_ P.M. inclusive for a total of \_\_\_\_\_ working days.

I was unfit for work on account of illness during this period and request a paid/unpaid (circle as appropriate) leave of absence due to that illness.

Did this illness arise as a result of a service connected incident? \_\_\_\_\_ Yes/No

Name of treating physician \_\_\_\_\_ Address \_\_\_\_\_ Telephone No. \_\_\_\_\_  
(print) (print)

Received: \_\_\_\_\_ Pass No. \_\_\_\_\_ Date \_\_\_\_\_  
Employee's Signature Supervisor

**Failure to submit this application within three (3) days after returning to work will result in loss of pay for the period in question and may also result in disciplinary action against the employee. Where absence is for more than two (2) days, this certification must be completely filled out by the attending physician before sick leave with pay will be approved.**

Do Not Write Below This Line

**DOCTOR'S CERTIFICATION (For Doctor's Use Only)**

I hereby certify that \_\_\_\_\_ was treated or evaluated by me on the date/s indicated for an illness.  
Employee's Name

Dates of treatment or evaluation:

Home \_\_\_\_\_ Office \_\_\_\_\_ Hospital \_\_\_\_\_

EXPECTED DATE OF RETURN TO WORK: \_\_\_\_\_

**I further certify that this illness so incapacitated this employee that he/she was incapable of performing his/her duties during the period from: \_\_\_\_\_ to \_\_\_\_\_, and that the information in this section, which will be used for payment purposes, is truthful.**

Physician Stamp

Date \_\_\_\_\_

Physician's Signature/Tax ID No. \_\_\_\_\_

# Departmental Report

## *Departmental Referral to Absentee Control*

REASON FOR REFERRAL  
(check box if appropriate)

Remarks \_\_\_\_\_

☐ Review for incomplete certification

☐ Review for fraudulent/altered certification

☐ Review-is period of absences consistent with illness?

Reviewed by

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

☐ Other \_\_\_\_\_

### LAST 12 MONTH USAGE REPORT

Substantiated  
Instances

Unsubstantiated  
Instances

Prior to  
Request

Post  
Request

### ACTION ON APPLICATION

Approved Paid \_\_\_\_\_ Days \_\_\_\_\_ Hours

Unpaid \_\_\_\_\_ Days \_\_\_\_\_ Hours

Disapproved \_\_\_\_\_ Days \_\_\_\_\_ Hours

Sick Leave Control List \_\_\_\_\_ Yes/No

Signature \_\_\_\_\_

*Department Head or Designee*

Reason for Disapproval: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_