



# SICK LEAVE TRANSFER

REQUEST TO USE

## Part I - Request to Use Donated Sick Leave

*I certify that I have suffered an illness, accident or injury. I further certify that I have expended all my personal leave credits and this is to request use of donated sick leave hours to cover my absence due to my current personal illness, accident or injury.*

*I authorize my employer to use my name and release a general description of the medical circumstances in order to determine my eligibility in accessing this benefit.*

Date Absence Began or Will Begin: \_\_\_/\_\_\_/\_\_\_ Signed: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Signer must check where applicable:  Self  Spouse or other authorized person representing employee.

## Part II - Medical Documentation

### THE FOLLOWING IS CONFIDENTIAL MEDICAL INFORMATION

*Based on my current illness, accident or injury, I am applying for donated sick leave hours from my employer's sick leave transfer plan. I hereby authorize any medical practitioner who has examined me with respect to my current illness, accident or injury, to complete Part II of this form and answer any relevant questions that may be asked by the Agency Sick Leave Transfer Plan Administrator in order to determine my eligibility for this benefit.*

Employee's Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Representative's Signature (if applicable): \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Print Representative's/Employee's Name: \_\_\_\_\_

### TO BE COMPLETED BY THE TREATING MEDICAL PRACTITIONER ONLY

Print Medical Practitioner's Name: \_\_\_\_\_ Business Telephone: ( ) \_\_\_\_\_

Signature of Medical Practitioner: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

State/License Number: \_\_\_\_\_

Date of which patient was first examined for current condition: \_\_\_/\_\_\_/\_\_\_

Date patient is expected to recover or be released to duty: \_\_\_/\_\_\_/\_\_\_ Check one:  Partial  Full

Patient may return on \_\_\_/\_\_\_/\_\_\_ with the following restrictions: \_\_\_\_\_

Return this form (**marked confidential**) to: \_\_\_\_\_

**INSTRUCTIONS FOR AUTHORIZED USE OF THIS FORM:** In order for the patient to comply with the eligibility requirements, the treating medical practitioner must complete this form and return it to the patient's employer directly or via the patient.