

Application for Leave of Absence Due to Illness

SIXTY PERCENT (60%) SUPPLEMENTARY PAY

TO BE PREPARED
IN DUPLICATE

DIVISION _____ DEPARTMENT _____ DATE _____ 19 _____

I, _____ Title _____ Pass No. _____

Rate _____ Pay Location _____ hereby apply for leave of absence from duty, with 60% pay, on account of illness or injury (from causes other than accident while on duty) in accordance with statement below:

Absent from _____, 19 _____, _____ A.M. to _____, 19 _____, _____ A.M. inclusive.
If absence is due to a non-service accident, state where, when, and how accident occurred.

I was unable to work during said period because _____

Did accident occur while working for employer other than T.A.? _____

(Signature)

(This certification must be completely filled out by the attending physician before payment for sick leave at 60% pay will be passed upon.)

DOCTOR'S CERTIFICATION

Patient's Name _____ Age _____ Sex _____
First Middle Last

I hereby certify that the above named employee was treated by me on the dates and for the illness noted below:

1) DIAGNOSIS _____

a. Patient's Symptoms _____

b. Objective Findings _____

2) TREATMENT: 1. _____
2. _____
3. _____

3) DATES OF TREATMENT:
(A) Home _____
(B) Office _____
(C) Hospital _____

I further certify that this illness so incapacitated this employee that he was unable to perform his duties during the following period:
From _____ To _____

I make this certification knowing that the above mentioned employee will use it as the basis of an application for sick leave with 60% pay.

Date _____

Signature _____ M.D.

Address _____

Tel. No. _____

DEPARTMENT REPORT

First Working Date of Absence _____ Total of Sick Days Off _____ Sick Hrs. Off _____ Excl. RDO & Holidays

Visiting Doctor Code 1 By Doctor at Home or Office Code 2 No Doctor Code 3 At Hospital

Pass No. _____ Payroll No. _____ Title Code _____ Section _____ Date of Appt. _____

Investigation: Code 1 Name submitted to Special Inspection Dept. but not investigated.
 Code 2 Investigated but not found at home.
 Code 3 Investigated and found at home.
 Code 4 Name **NOT** submitted for investigation.

Remarks _____

Interim Report: Code 1 This is the **ONLY** report for this illness.
 Code 2 This is the first of several reports to be submitted for same illness.
 Code 3 Previous report or reports were submitted.
 Code 4 Final report where interim reports have been submitted.

First Day of Absence (if previous application was submitted) _____

Regular Days Off: Code 1 Saturday & Sunday Code 5 Wednesday & Thursday
 Code 2 Sunday & Monday Code 6 Thursday & Friday
 Code 3 Monday & Tuesday Code 7 Friday & Saturday
 Code 4 Tuesday & Wednesday Code 8 Other _____

	Days	Hours*
Unused (60%) Sick Leave Allowance _____	_____	_____
Approved with pay on this application _____	_____	_____
Balance (60%) allowance _____	_____	_____

	Days	Hours*	Night Diff. Hrs.
APPROVED with 60% pay _____	_____	_____	_____
TAX EXCLUDED _____	_____	_____	_____

DISAPPROVE _____ (Reason)

AMOUNTS TO BE PAID

TYPE	CODE	HOURS*	PRO RATE	DAYS	NIGHT DIFF. HRS. MIN.	RATE
	8-9	10-14	15-16	17-19	34-38	39-44
Current 60% sick	02					
Non-current 60% sick	04					
TOTALS						

_____ (Certifying Official)	_____ (Title)	_____ (Date)
_____ (Department Head)	_____ (Title)	_____ (Date)

*Show 60% of pay hours for days allowed