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West Islip Union Free School District

APPLICATION FOR INCAPACITATING ILLNESS OR ACCIDENT SICK LEAVE

All applications must be received no later than the applicant's 20th sick day.

Section 1: *To be filled out by requesting teacher*

Name _____
Last First Middle Initial

Address _____
Street Town Zip

Home Phone _____ Cell Phone _____

Home School _____ Department _____

I agree to provide permission for my health care provider to supply information relative to the incapacitating illness or accident for which I submit this application.

Applicant's Signature _____ Date _____

Section 2: *To be filled out by health care provider*

Your patient has requested a leave under the "Incapacitating Illness or Accident" clause in the collective bargaining agreement for the West Islip Teachers' Association. An incapacitating illness or accident is one that is under treatment by a physician and which makes it impossible for the teacher afflicted to continue working.

Answer fully and completely all applicable parts. Several questions seek a response to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can. Limit your responses to the condition for which the employee is seeking leave.

Physician _____

Address _____
Street Town Zip

Telephone _____ Fax _____

Type of Medical Practice/ Specialty _____

Approximate date condition commenced _____

Projected date for return to work _____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential care facility?

Yes _____ No _____ If yes, date(s) of admission _____

continued on next page (over)

Was the patient referred to other health care provider(s) for evaluation or treatment?

Yes _____ No _____ If yes, state the nature of such evaluation and/or treatment.

_____

_____

_____

Is the employee unable to perform any of his/her job functions due to the condition?

Yes _____ No _____ If yes, specify the job functions the employee is unable to perform.

_____

_____

_____

Describe any other relevant medical facts related to the condition for which the employee seeks leave (symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment).

_____

_____

_____

Describe any accommodations that may be provided to facilitate the employee's return to work or support the employee upon return to work.

_____

_____

_____

Only the physician directly treating the patient may affix his/her signature below.

Physician's Signature _____ Date _____