Employee Sick Bank Application

Employee:

PLEASE COMPLETE THIS SECTION, SIGN AND HAVE YOUR PHYSICIAN COMPLETE IN DETAIL THE BACK OF THIS FORM AND RETURN TO OAKLAND UNIVERSITY, EMPLOYEE RELATIONS DEPARTMENT, 144 NORTH FOUNDATION HALL, ROCHESTER, MI 48309-4401.

Name: _____ Date: _____
(Please Print)

Address: _____Telephone: _____
(Street) (City) (Zip Code)

Department: _____Supervisor: _____Telephone: _____

If absence is the result of an illness, give nature of disability and date you first noticed symptoms.

_____

_____

_____

If your disability is the result of an accident, please give date, time, place, and nature of accident.

_____

_____

_____

_____
Date first consulted physician in connection with this disability

_____
Date disability began

_____
Last work day

_____
When will you be able to resume work?

Name and address of physician consulted

_____

_____

_____

Have you been able to do any work since that date? YES ___ NO ___
If yes, please explain: _____
_____
_____

I hereby declare that the answers given by me in this sick bank disability grant application are complete and true to the best of my knowledge. I also authorize the release of all medical information that is related to my condition.

Employee Signature: _____ Date: _____

Physician's Statement

IN ORDER FOR AN APPROPRIATE EVALUATION TO BE MADE CONCERNING THE ELIGIBILITY FOR SICK BANK BENEFITS EACH QUESTION MUST BE ANSWERED IN DETAIL. PLEASE PRINT OR TYPE AND DO NOT ABBREVIATE. FAILURE TO DOCUMENT SPECIFICALLY WHY THE PERSON IS DISABLED MAY RESULT IN THE LOSS OF PAY.

Name of patient: _____

Date symptoms first appeared or accident occurred: _____

Date patient first consulted you for treatment of condition described below: _____

Diagnosis: _____

_____

_____

Is condition incidental to pregnancy? _____

If surgery is performed, give type of surgery and date(s) of surgery: _____

_____

If patient is not totally disabled, what restrictions or temporary accommodations can be made in order to return your patient to work? (i.e.: shorter workweek, limitation of job functions performed, etc.)
_____

_____

_____

_____

Patient is totally disabled from returning to work, even with restrictions: YES ___ NO ___

If yes, please state specific medical reason(s): _____

_____

_____

_____

Expected date of return to work: _____ _____ _____
Month Date Year

Please print physician's name: _____

Physician's Signature: _____Date: _____

Address: _____ Telephone Number: _____

_____