

NOTICE OF EMPLOYEE ILLNESS OR ACCIDENT - NOT WORK RELATED

EMPLOYEE NAME _____ DATE _____

CURRENT ADDRESS _____

CURRENT PHONE _____ SOCIAL SECURITY NO. _____

DEPARTMENT/DIVISION _____

The above referenced employee has been absent for five (5) consecutive workdays due to personal illness/injury beginning: (Date) _____ for _____

The employee expects to return to work (Date) _____

It is the department's responsibility to send to the employee the Attending Physician's Supplementary Statement along with the pink copy of this form.

It is the employee's responsibility to have the Physician file the completed statement with the Occupational Health Clinic. Upon receipt of the supplemental form, and evaluation of same, the Clinic will recommend the need for medical leave.

Signed _____

Phone# _____

DISTRIBUTION: WHITE: Occupational Health Clinic YELLOW: Department PINK: Employee