Bi-State Development

Sick Leave Pay / Sick Leave Application Form

Attention Employee:

Please take note of the following steps below when applying for either Sick Leave Pay or Sick Leave due to incapacity for a continuous period.

Step 1 - Make sure you have properly advised your Division/Department Manager of your need for leave and provide an estimate of how long you may be unable to work.

Step 2 - Upon acquiring this application for Sick Leave Pay/Sick Leave, contact Absence Management at **314-982-1597** to check eligibility for possible Family and Medical Leave (FMLA) protection. FMLA must be applied to the first 12 weeks involving a qualified serious health condition that incapacitates an employee from performing their normal job duties.
While a separate FMLA certification is generally required for FMLA leave, if the information provided on this form is sufficient for BSD to determine that the reason for the time off qualifies under a serious health condition, BSD reserves the right to designate the employee's time off as Family and Medical leave.

Step 3 - Employee to complete the EMPLOYEE'S STATEMENT section at the top of the application on Page 1.

Step 4 - Forward the application to the attending physician for completion of the ATTENDING PHYSICIAN'S STATEMENT section starting at the bottom of Page 1. Have the physician's office fax the completed form to Absence Management at the fax number noted at the bottom of Page 2 **(314) 335-3474**.
Personal health information on Page 2 will not be shared with your Division/Department Manager.

Step 5 - Employee may want to follow up with Absence Management to make sure application was received by calling **314-982-1597**. Applications received shall be reviewed and Page 1 only will be forwarded to your Division/Department Manager for processing if pay is involved.

Step 6 - A newly completed application for sick leave/sick pay shall be required **every 4 weeks** if the physician does not provide a clearly stated return to work date on the form **(Question #36)**.

Step 7 - Contact your Division/Department Manager upon learning of a return to work date. Employee is required to be cleared for duty through BarnesCare in situations where the employee has been absent from work for 3 or more days. Your Division/Department Manager will provide you with the necessary paperwork and instructions on where to go and how to be cleared for work. A release for duty from your attending physician is required for the clearing process through BarnesCare, have the form with you.

Step 8 - Paperwork provided to you at BarnesCare shall be given to your Division/Department Manager as proof you have been cleared for work. Don't delay in presenting this document.

BI-STATE DEVELOPMENT
APPLICATION FOR SICK LEAVE and/or SICK LEAVE PAY

EMPLOYEE'S STATEMENT

New Application required <u>every 4 weeks</u> 'if' the physician does not provide a RTW date

1. FULL NAME	2. EMPLOYEE BADGE #	3. DATE OF BIRTH	
4. MAILING ADDRESS	5. CITY	6. STATE	7. ZIP CODE
8. CONTACT PHONE NUMBER:	9. EMPLOYMENT LOCATION/DEPT.		
10. DATE EMPLOYED	11. POSITION	12. PAID SICK DAYS REQ'D	

13. OPERATORS ONLY
REGULAR ☐
EXTRA BOARD ☐

14. NATURE OF CLAIM(S)
ILLNESS OFF THE JOB ☐ ILLNESS ON THE JOB ☐
INJURY OFF THE JOB ☐ INJURY ON THE JOB ☐
ASSAULT ON THE JOB ☐

15. HAVE YOU APPLIED/RECEIVING OR PLANNING TO MAKE AN APPLICATION FOR WORKER'S COMPENSATION OR OTHER COMPANY ASSOCIATED BENEFITS FOR THIS CONDITION? YES ☐ NO ☐ If yes, explain: _____

16. **I HEREBY AUTHORIZE THE ATTENDING PHYSICIAN(S) AND/OR MEDICAL FACILITY(S) TO RELEASE ALL INFORMATION NECESSARY TO COMPLETE MY APPLICATION FOR COMPANY BENEFITS. (Sick Leave/Sick Pay, Injury or Disability Pension)**

_____
SIGNED (APPLICANT) DATE

SUPERVISOR'S STATEMENT

17. APPLICATION REC'D BY: _____ DATE REC'D: _____

18. LAST DAY WORKED	19. FIRST COMPLETE DAY OFF	20. DATE RETURNED TO WORK	TIME: _____ (Military Time)
21. RUN NUMBERS(S):	22. REG. DAYS OFF:	23. INDICATE IF CONTINUATION YES ☐ NO ☐	
24. SICK HOURS ACCUMULATED:	25. SICK HRS. PAID THIS APPLICATION	26. SICK HRS. ACCUMULATED BUT NOT PAID	

27. NUMBER OF HRS. PAID: @ RATE = $

EX OUT (x) EMPLOYEE'S REGULAR DAYS OFF, PAID HOLIDAY AND VACATION PERIOD - RECORD A W (w) TO INDICATE WAITING PERIOD - CIRCLE (o) IN RED - DAYS FOR WHICH SICK PAY IS REQUESTED

28.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
19	20	21	22	23	24	25	26	27	28	29	30	31					

_____ MONTH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
19	20	21	22	23	24	25	26	27	28	29	30	31					

_____ MONTH

MANAGER APPROVAL: APPROVED ☐ DENIED ☐ AUTHORIZED SIGNATURE: _____

DATE REC'D: _____ ☐ APPROVED FOR PROCESSING ☐ UNDER INVESTIGATION

TIME: _____ **ABSENCE MANAGEMENT DEPT.** _____

ATTENDING PHYSICIAN'S STATEMENT

29. PATIENT'S NAME: _____

30. IS THE CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? NO ☐ YES ☐	31. IF AN INJURY/SICKNESS ON-THE-JOB DATE SYMPTOMS APPEARED: _____
32. DATE OF PATIENT'S LATEST EVALUATION FOR THIS CONDITION: DATE: _____	33. APPROXIMATE DATE CONDITION COMMENCED: DATE: _____
34. WAS PATIENT ADMITTED TO THE HOSPITAL? NO ☐ YES ☐ IF YES, FROM: _____ THROUGH _____	35. WAS OUTPATIENT SURGERY PERFORMED? NO ☐ YES ☐ IF YES, SURGERY DATE: _____
36. WAS PATIENT ADVISED TO REMAIN OFF WORK? NO ☐ IF YES ☐ FROM: _____ * THRU: _____	37. WAS THE PATIENT REFERRED TO OTHER HEALTHCARE PROVIDER? NO ☐ YES ☐ IF YES, WHO: _____

*__Question #36__ must either reflect an estimated RTW date, next appointment date, if applicable, or an actual RTW date if known.

ATTENDING PHYSICIAN'S STATEMENT (CONTINUED)

38. OTHER PRIOR EVALUATION/TREATMENT DATES WITHIN LAST 12 MO. FOR THIS CONDITION _____

39. WAS MEDICATION PRESCRIBED (OTHER THAN OVER-THE-COUNTER)
NO ☐ YES ☐

40. DATE OF NEXT EVALUATION AND/OR TREATMENT DATE: _____

41. DESCRIBE RELEVANT MEDICAL FACTS (**DIAGNOSIS**, SYMPTOMS, PROGNOSIS, TREATMENT REGIMEN, ETC) _____

42. BASED ON THE EMPLOYEE'S JOB POSITION, WHAT ESSENTIAL FUNCTIONS OF THE JOB CAN THEY NOT PERFORM AND EXPLAIN WHY? _____

43. **PHYSICIAN'S NAME & PRACTICE/SPECIALTY (Print)**	**PHYSICIAN'S SIGNATURE**

Address	City/Town	State	Zip Code

Telephone #	E-mail Address AND/OR FAX #	Date Completed:

Page 1 and Page 2 of this form must be faxed directly from the attending physician's practice to Bi-State's Absence Management Department to protect personal health information. TSM/Managers cannot accept or process a Sick Leave/Sick Leave Pay application prior to an Absence Management review.

Employee is to ensure that Section 1 **[Employee's Statement**] is complete and Section 3 **[Attending Physician's Statement]** is complete and has been signed by the physician prior to faxing.

Fax Number: (314)-335-3474

Return-to-Work Release Form

Instructions:

Employee: Return the completed form to your Division/Facility to obtain a Metro Return-To-Work Authorization Form to take to Barnes Care.

Health Care provider: **This form must be completed and faxed directly from the healthcare provider's office to (314)-335-3474.**

EMPLOYEE SECTION:

Employee name: _____ Badge No. _____

Job Title: _____ Facility: _____

Leave Start Date: _____

PHYSICIAN SECTION:

The employee is clear to return to work without restrictions, on _____
Date

_____
Physician Name (Print)

_____
Address

_____
City State Zip

_____ _____
Phone No Fax No.

_____ _____
Physician's Signature ` Date:

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BiStateDev.org