

STATE EMPLOYEES' LEAVE BANK
MEDICAL REQUEST FORM

TO BE COMPLETED BY EMPLOYEE'S TREATING PHYSICIAN

PATIENT'S NAME: _____

DIAGNOSIS(ES): _____

ICD CODE(S): _____

SUMMARY OF TREATMENT(S) & PROCEDURE(S): _____

CPT CODE(S): _____

SURGERY DATE (IF APPLICABLE): _____

HOSPITALIZATION DATE(S) (IF APPLICABLE): From: _____ To: _____

CAN EMPLOYEE WORK IN A MODIFIED CAPACITY? YES _____ NO _____

IF YES, EXPLAIN RESTRICTIONS FOR MODIFIED DUTY:

DATE EMPLOYEE IS LIKELY TO RETURN TO:

MODIFIED DUTY: _____ **FULL DUTY:** _____

PHYSICIAN'S SIGNATURE

PHYSICIAN'S NAME (PRINTED)

PHYSICIAN'S PHONE NUMBER

DATE FORM COMPLETED

This document shall be treated as a confidential medical record; it shall not be placed in the employee's personnel file. Only those individuals with a need to know this information will be given access to it. An employee who fails to appropriately safeguard the confidentiality of this information will be subject to disciplinary action, including termination from State Service.