STATE EMPLOYEES' LEAVE BANK
MEDICAL REQUEST FORM

TO BE COMPLETED BY EMPLOYEE'S TREATING PHYSICIAN

PATIENT'S NAME: ____

DIAGNOSIS(ES): ____

____

ICD-9 CODE(S): ____________ ____________ ____________ ____________

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

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____

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.

MS 402-LB
(Revised February 2013)