Union Colony Schools Sick Leave Bank Claim

File:GBGH-E

Employee Section- Please print and complete in full

Office Use Only

_____
Return to Work Date

_____
Dates of Non-Paid Leave (5)

_____
1st Date of Sick Bank Use

_____
Employee Name

_____
Employee Mailing Address City State Zip

___/___/_____ _____ _____ _____ _____
Date of Birth Social Security Number Date of accident include details

_____
Date symptoms first appeared

I authorize any physician, medical practitioner, hospital, clinic other health facility consumer reporting agency, the medical information Bureau, social security administration, insurance company or reinsurance company to release all medical information about me in its possession to Union Colony School or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding my medical history, mental or physical condition, or treatment. I understand that Union Colony Schools will use the information obtained to determine eligibility for benefits under the existing policy. Union Colony Schools will not release information obtained to any person or organization performing business in connection with my application, claim or as may be lawfully required of permitted, or as I may further authorize. I know that I may request and receive a copy of this authorization. I agree that a photo copy of this authorization shall be as valid as the original.

Signature of Employee_____ Date ____/___/_____

Physician Section-Please complete in full and return to prevent delay in processing

Diagnosis (es) _____

Is patient's disability due to: **A)** Employment yes/ no **B)** Accident yes/ no **C)** Pregnancy yes/ no

If disability is due to pregnancy, please indicate date of delivery Actual___/___/___or Estimated___/___/__

Please indicate LMP date ___/___/___Please indicate type of delivery: Vaginal C-Section Multiple Births

Date first symptoms appeared ___/___/_____ Date of first visit for this condition ___/___/___

Date of treatment for this condition _____

Dates patient was totally **disabled** (unable to work) from ___/____/___ to ___/____/___

Dates patient was **hospitalized** (if applicable) from ___/____/___ to ____/____/____

If patient is still disabled give date of anticipated **release to return to work** ____/___/____

Surgical procedure(s) date(s) type(s)

CPT_____

Is patient still under your care for this condition? Yes No

If yes are there medically necessary activity restrictions? Yes No

If yes please **specify restrictions**

_____

Date of patient's next appointment ___/___/___

Printed name of Physician _____Specialty _____

Printed address of Physician _____ Telephone Number _____

Fax number ( )_____-_____ e-mail address _____ Tax ID# _____

Signature of Physician _____ Date _____