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/injur

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 Stateme 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

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COUNTY FORM 017