

NOTE: Top and bottom portions of this form must be filled out in their entirety and returned to Employee Health Services to insure continuation of salary.

REQUEST ABSENCE FOR PERSONAL ILLNESS / ILLNESS IN FAMILY	THE SCHOOL DISTRICT OF PHILADELPHIA EMPLOYEE HEALTH SERVICES - SUITE 134 440 N. BROAD STREET - PHILADELPHIA, PA 19130
---	---

♦ A NEW CARD MUST BE SUBMITTED FOR EACH PAYROLL PERIOD --- NOT TO EXCEED 10 DAYS.
 ♦ FAILURE TO SUBMIT CARDS MAY LEAD TO DISCIPLINARY ACTION.
 ♦ EMPLOYEES ON LONG-TERM ILLNESS/ILLNESS IN FAMILY MAY NOT LEAVE THE CITY WITHOUT PRIOR APPROVAL FROM EMPLOYEE HEALTH SERVICES.

▶ SECTION I - COMPLETED BY EMPLOYEE

Employee's Last Name	First Name	M.I.	Employee ID	Date
Home Address	City	State	Zip Code	Home Phone
Work Location (School/Office)	Organization No.	Position Title		
Number of Days Absent	From Date (Month/Day/Year)	To Date (Month/Day/Year)	Anticipated Date of Return	
Signature of Employee	Signature of Principal/Administrator		Date	

== = THIS CARD DOES NOT REPLACE A MEDICAL REPORT FROM YOUR DOCTOR == =

SEH-3 Part 1 (Rev. 11/11) Comm. Code 61602445418

▶ SECTION II - AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION - ALL INFORMATION WILL BE KEPT CONFIDENTIAL

<input type="checkbox"/> FOR EMPLOYEE ILLNESS I, the undersigned, authorize the release of all information regarding this illness to the Office of Employee Health Services, for which I am requesting personal illness absence. Name of Employee: _____ Employee I.D.: _____ Signature: _____ Date: _____	<input type="checkbox"/> FOR ILLNESS IN THE FAMILY Name of Employee: _____ Name of Family Member: _____ Relationship to Employee: _____
---	---

▶ SECTION III - COMPLETED BY EMPLOYEE'S PHYSICIAN OR FAMILY MEMBER'S PHYSICIAN

Name of Patient: _____ Date of Last Visit: _____

I certify that the above patient is / was under my professional care from (date) _____ to _____

The patient's diagnosis/diagnoses: _____

___ Disability From Pregnancy (EDD: _____) Other: _____

== = FORGERY OF PHYSICIAN'S SIGNATURE IS SUBJECT TO DISCIPLINARY ACTION == =

Physician's Name: _____ Telephone: _____	Date employee may return to work (Do not indicate indefinitely)
Address: _____ City _____ State _____ Zip Code _____	
Signature: _____ Date: _____	

SEH-3 Part 2 (Rev. 11/11) Comm. Code 61602445418