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

☐ **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: _____

☐ **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: _____

Address: _____ City _____ State _____ Zip Code _____

Signature: _____ Date: _____

Date employee may return to work
(Do not indicate indefinitely)

_____

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