

Indiana State University
Sick Leave Transfer Medical Form

1. Employee's Name: _____
2. Patient's Name (If different from employee): _____
3. Diagnosis (Illness or Injury): _____
4. Date condition commenced: _____
5. Probable duration of condition: _____
6. Treatment to be prescribed. Indicate number of visits, general nature and duration of treatment, including referral to other provider of health services. Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week.

a. By Physician/Practitioner:

b. By another provider of health services, if referred by Physician/Practitioner:

Check **Yes** or **No** on the line below as appropriate:

- | | YES | NO | |
|----|-------|-------|--|
| 7. | _____ | _____ | Is inpatient hospitalization of the employee required? |
| 8. | _____ | _____ | Is the employee able to perform work of any kind? (If "No", skip Item 9) |
| 9. | _____ | _____ | Is employee able to perform the functions of their position? |

10. Signature of Physician/Practitioner: _____ Date: _____

11. Print Physician/Practitioner's Name: _____

12. Type of Practice (Field of Specialization, if any): _____

13. Address of Physician/Practitioner: _____

14. Physician's Phone No.: _____ Fax No.: _____