

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 CARD MUST BE SUBMITTED FOR ABSENCES IN EXCESS OF 3 CONSECUTIVE DAYS- ONE CARD 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 - (SECTIONS I AND II COMPLETED BY EMPLOYEE)

Employee's Last Name	First Name	M.I.	Social Security Number	Date
Home Address	City	State	Zip Code	Home Phone
Work Location (School/Office)	Organization No.	Position Title		
Number of Day Absent	From Date (Month/Day/Year)	To Date (Month/Day/Year)	Anticipated Date of Return	
Signature of Employee	Signature of Principal/Administrator (Employee not required to obtain signature)			Date

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

SEH-3 Part 1 (Rev. 1/09) 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: _____

Social Security No. _____

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: _____)

=== 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. 1/09) Comm. Code 61602445418