PennState
Human Resources

SICKNESS AND ACCIDENT SUPPLEMENT CLAIM FORM

THE COMPLETED FORM MUST BE RETURNED TO ABSENCE MANAGEMENT AT absence@psu.edu or (814) 863-6227 (fax).

SECTION 1: TO BE COMPLETE BY EMPLOYEE

1. _____ _____ _____
   Employee Name PSU ID# Date of Birth
2. College or Unit Name: _____
3. Is this claim the result of a work-related injury? _____
   If yes, please furnish details:
   _____
   _____
4. What is the nature of your illness or injury?
   _____
   _____
5. Date of injury or illness: _____
6. How long do you expect the disability to continue? _____
7. Are you covered by another sickness and accident plan? _____
   If yes, furnish the name and address of the company.
   _____
   _____
8. Please list dates, facilities and physicians that you are treating with for your condition.

DATE	FACILITY	PHYSICIAN

I hereby certify that the above statements are correct and I authorize the release of information from the above named physicians and facilities.

_____ _____
Employee's Signature Date

Penn State Absence Management
Phone: (814) 865-1782, Fax: (814) 863-6227
E-mail: absence@psu.edu

SECTION 2: TO BE COMPLETE BY ATTENDING PHYSICIAN

1. Patient's Name:

   _____

2. Diagnosis and concurrent condition:

   _____

   _____

   _____

   _____

3. Is the condition due to injury arising out of patient's employment? Yes or No
4. Is the employee expected to return to work? Yes or No

   If so, what is the approximate date of return? _____

5. Please list dates of treatment below.

DATES OF SERVICE	FACILITY	DESCRIPTION OF MEDICAL SERVICES RENDERED

_____ _____

Physician's Signature Date

_____

Physician's Name (Print)

_____

Facility Name and Street Address

_____ _____ _____

City State Zip Code

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SECTION 3: TO BE COMPLETE BY ABSENCE MANAGEMENT

1. Has the employee used more than 6 sick days of accumulated sick leave without a physician's certification or FMLA in the past 12-month period immediately preceding the absence due to illness or injury? _____
2. Normal days off: _____
3. Human Resource Contact: _____
4. Supervisor: _____
5. Date employee's absence commenced: _____
6. Leave of absence status: _____
7. Employee's Hourly Rate: _____
8. Sick/Vacation Hours Available: _____
9. Last day of full pay: _____

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