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 that 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.: ___________________