ATTACHMENT A DEPARTMENT OF CORRECTION SICK LEAVE SLIP

Name of Employee:
Institution/Division:
I hereby report absence on account of sickness on the following date(s) and request the use of my sick leave benefits for the reason checked below:
use of my sick leave benefits for the reason checked below:
() Incapacitated for performance of duties by personal illness/injury.
() Serious illness of family member.
() Other, such as, medical or dental appointments, birth or adoption of a child.
I notified the institution/division on the first day of absence:
Day/Time
Who reported to:
I certify that the above statements are true and correct.
Signature of Employee Date
FOR UNIT 4 EMPLOYEES ONLY.
() Substantiated Absence
() Unsubstantiated Absence
Signature of Superintendent/Division Head or designee Date

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MASSACHUSETTS DEPARTMENT OF CORRECTION ILLNESS CERTIFICATION FORM

PERSONAL ILLNESS OF EMPLOYEE

TO BE COMPLETED BY MEDICAL PROVIDER (Additional information may be attached)

Medical Provider (print name):		
Licensed Profession (circle one):	licensed physician physician's assistant nurse practitioner chiropractor dentist	
Address:		
Phone Number:	·	
	was examined by me on	
(Patient Name)	(Da	ite)
He/she was incapacitated by person	nal illness or injury due to	
(Nature of illness	s unless it is of a confidential nature)	
	d medical or dental professional could not ricking hours for purposes of medical treatmed dental condition.	
He/she could not perform his/her du	uties on	
	(Date of incapacitation)	
and may return to work with no rest	trictions on	*
		order and communication
Signature of Medical Provider*	Date	ACCORDINATION AND AND AND AND AND AND AND AND AND AN
(*If a signature stamp is used, it mu authorized to do so.)	st be accompanied by the initials of someon	ne