



AUTHORIZATION FOR DISABILITY LEAVE AND RETURN TO WORK

Name of Patient (full): _____ Date of Birth: _____ Soc. Sec. Number: _____

Present Address—Street or Rural Route: _____

City: _____ State: _____ Zip Code: _____

Employed by State of Illinois: _____
(Agency, Board, Commission, Department)

Facility: _____ Address: _____

**COMPREHENSIVE MEDICAL INFORMATION IS REQUIRED IN ORDER TO EVALUATE THE EMPLOYEE'S
CLAIM FOR A DISABILITY LEAVE OF ABSENCE OR SUBSEQUENT RETURN TO WORK**

1. DIAGNOSIS (including any complications):

(a) Date of last examination: Month: _____ Day: _____ 20 _____

(b) Diagnosis including any complications: _____

(c) Subjective symptoms: _____

(d) Objective findings (including information derived from x-rays, EKG's, laboratory data and any clinical findings): _____

2. DATES OF TREATMENT:

(a) Date of first visit: Month _____ Day: _____ 20 _____

(b) Date of last visit: Month _____ Day: _____ 20 _____

(c) Frequency: Weekly Monthly Other—(Please specify) _____

3. TREATMENT:

(a) Please describe any surgery and / or , medication prescribed: _____

(b) Will treatment substantially improve function and employability? Yes No If yes specify: _____

IMPORTANT NOTICE
This state agency is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under 20 ILCS 415/8c(2). Disclosure of this information is **VOLUNTARY**. This form has been approved by the State Forms Management Center.

4. PROGRESS: (Please check appropriate box provided below):

- (a) The patient has: Recovered Improved Remained Unchanged Retrogressed
- (b) The patient is: Ambulatory House Confined Bed Confined
- (c) Has the patient been hospital confined because of current condition? Yes No

If yes, give name and address of hospital: _____

Confined from: Month _____ Day _____ 20 Through Month _____ Day _____ 20

5. LIMITATION: (If there is a limitation, check appropriate box and describe below):

- Standing Climbing Bending Use of Hands Stooping
 Lifting Psychological Other (Please specify): _____

6. PHYSICAL IMPAIRMENT: (*As defined in Federal Dictionary of Occupational Titles):

- Class 1 --No limitation of functional capacity; capable of heavy work * No restrictions(0-10%)
 Class 2 -- Medium manual activity * (15%-30%)
 Class 3 -- Slight limitation of functional capacity; capable of light work* (35%-55%)
 Class 4 -- Moderate limitation of functional capacity; capable of clerical / administrative (sedentary*) activity (60%-70%)
 Class 5 -- Severe limitation of functional capacity; incapable of minimal (sedentary*) activity (75%-100%)
 Remarks--

7. EXTENT OF DISABILITY:

- (a) In your opinion is patient now temporarily totally disabled?
- (b) If no, when was patient able to go to work?
- (c) If yes, what is the approximate date patient will be able to resume work?
- (d) In your opinion is patient permanently and totally disabled for employment?
- (e) If answer to (d) is yes, please explain.

<i>From Any Occupation</i>			<i>From Patient's Regular Occupation</i>		
<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Month	Day	Year	Month	Day	Year
		20			20
Month	Day	Year	Month	Day	Year
		20			20
<input type="checkbox"/> Yes			<input type="checkbox"/> No		
<input type="checkbox"/> Yes			<input type="checkbox"/> No		

8. REMARKS:

Attending Physician Signature: _____ Degree: _____ Date _____

PLEASE TYPE OR PRINT THE FOLLOWING INFORMATION:

Attending Physician's Name: _____

Physician's Office Street Address: _____

City: _____ State: _____ Zip Code: _____ Phone Number: _____

TO EMPLOYEES: You are responsible for having this form completed and returned to the appropriate person within your agency Within the time limits established by your agency. Your failure to comply may result in termination of your disability leave.