SPECIAL COLLECTIONS APPLICATION - Part A - Applicant

Requested number of days: _________

LAST NAME	FIRST NAME	WORK PHONE

MAILING ADDRESS	HOME PHONE	JOB TITLE/LOCATION

Have you exhausted your sick and personal leave? Yes _____ No _____

Explain the care you will be providing:

Applicant's designee for collection of approved Speical Collection days: ________________________________

Designee phone number: _________________________________

Applicant's Signature	Date

Part B: To be completed by Physician

Patient's Name	Patient's Relationship to Applicant

Medical Diagnosis

ICDM.9 Code:

Treatment Plan: (Explain in detail regiment of treatment prescribed, nature and duration of treatment, and prognosis)

Date condition commenced:

Probable duration of condition:

Is employee needed to care for family member? Yes _____ No _____

Estimate the period of time care is needed or the employee's presence would be beneficial: ________________

Physician Signature/Title/Phone Number	Date

INCOMPLETE INFORMATION WILL LEAD TO THE DENIAL OF THE SPECIAL COLLECTIONS APPLICATION

Revised: April 2017