Council Members
DOROTHY L. GOOSBY
EDWARD A. AMBROSINO
BRUCE A. BLAKEMAN
ERIN KING SWEENEY
ANTHONY D'ESPOSITO
DENNIS DUNNE, SR.

Town Clerk
NASRIN G. AHMAD

Receiver of Taxes
DONALD X. CLAVIN, JR.

WILLIAM F. SAMMON, JR.
Director

Town of Hempstead

Department of Human Resources

350 Front Street
HEMPSTEAD, N.Y. 11550
(516) 489-5000

ANTHONY J. SANTINO
Supervisor

DOCTOR'S REPORT FORM

TO EMPLOYEE: Under Section 13(d)(ii) of the Collective Bargaining Agreement, you have requested to utilize vacation leave in lieu of sick leave because you have exhausted all of your sick leave. Therefore, you are required to have this form completed by a doctor at your own expense. This report must be submitted to your department head (or designated representative) upon your return to work. If you fail to submit this report, then you shall be treated as if you were on leave without pay and the vacation leave in lieu of sick leave that you utilized shall be re-credited to your vacation bank and you will be treated as if you were on no pay status for said time period which may result in disciplinary action.

TO HEALTH CARE PROVIDER: Your patient has requested an absence under the Town of Hempstead policy allowing the employee to utilize vacation leave in lieu of sick leave. Please answer fully and completely all-applicable parts. Your answer should be your best estimate based upon your medical knowledge, experience and examination of the patient.

To my Health Care Provider: I, the below signed employee, hereby authorize you to release to the Town of Hempstead all information requested on this form.

EMPLOYEE INFORMATION: (To be completed by the Employee)

Employee's Printed Full Name: ______________________________

Address: ______________________________

Telephone No: ____________________ ***Cell No***: ____________________

Title: ______________________________

Department: ______________________________

Worksite: ______________________________

Work Schedule: ______________________________

Signature: ______________________________ ***Date***: ______________

HEALTH CARE PROVIDER INFORMATION: (To be completed by the Health Care Provider)

Health Care Provider's Printed Name: ____

Type of Practice/Medical Specialty: ____

Office Address: ______________________________________ ***Telephone No*:** ______________

Doctor's Signature: ____ ***Date***: ________________
(Signature required. Stamp not acceptable.)

REPORT OF EXAMINATION: (To be completed by the Health Care Provider)

Patient's Name: _______________________________________ ***Date of Exam***: ______________

Patient's Address: ____

Nature of illness or injury: ____

***Expected duration of this illness or injury*:** ____

Has the patient fully recovered at this time and is able to return to full duty? (Y/N) ___________

Is continued medication prescribed? (Y/N) ___________

If continued medication is prescribed, is patient able to fully perform his/her assigned duties and requirements of his/her employment with the Town of Hempstead while using prescribed medication? (Y/N) ___________

NOTE: If a question exists as to the patient's duties, please contact the Department of Human Resources for a copy of the patient's job specifications.

FOR TOWN OF HEMPSTEAD USE ONLY: (To be completed by the Employee's Department)

Date report received*:** _____________ ***by: ____
(Name and Title)

Number of sick and vacation leave hours used in this occurrence: ___________ ___________
Sick Vacation

Verification of Health Care Provider's report by: ____
(Name and Title)

Date of Verification: ____________

Copy of report sent to the Department of Human Resources on this date: __________________