



Duquesne University
600 Forbes Avenue
Pittsburgh, PA 15282
(412) 396-6677

MEDICAL ABSENCE CLAIM FORM

EMPLOYEE INFORMATION

Name _____ Social Security No. _____ Birth date _____
Present Address _____
(Number) (Street) (City) (State) (Zip)
Home Phone No. _____ Work Phone No. _____ Job Title _____
University Department _____ Supervisor's Name _____

EMPLOYEE'S STATEMENT

Please Mark (X) One of the Following Statements:

- ____ 1.) This medical absence claim **is not** due to an injury, accident, or illness that occurred while at, and due to, my work as an employee of Duquesne University.
- ____ 2.) I believe this medical absence claim **is** due to an injury, accident, or illness which occurred due to my work as an employee at Duquesne University. The incident occurred on _____ at _____.
(Date) (Place)

(If you checked number 2 an Accident Investigation Report must be completed. If you have not completed this report please contact your supervisor to obtain a copy and complete the report. Have your supervisor review and sign the report and return to Genny Hughes, Room 202A Fisher Hall. 412-396-6677)

First Date of Absence from Work for this Claim: _____
(Date)

I hereby authorize any physician, medical practitioner, hospital, pharmacy, or provider of medical services to release any information to Duquesne University, my employer, about my mental or physical history, prescriptions, care and treatment (including drug and alcohol and psychiatric information if any) that relates to or affects my employment at Duquesne University. I understand that the information released under this authorization will be used by Duquesne University solely for the purpose of evaluating my mental and/or physical ability to do my job at Duquesne University. A photocopy of this authorization will be considered as effective and valid as the original.

Signed: _____ Date: _____
(Employee Signature)

Witness: _____ Date: _____

Physician/ Medical Provider Should Complete Requested Information On Back

PHYSICIAN/MEDICAL PROVIDER'S STATEMENT

Please review the job requirements and answer the questions below as they relate to the ability or inability of the listed individual to perform their job at Duquesne University. Please complete this form in light of that review and of your medical inquiries and examinations. Your responses and input are very important in helping Duquesne University and your patient determine his/her work status and therefore their wage compensation applicable to that status. Duquesne University makes every attempt to accommodate work restrictions if necessary. If you have any questions regarding this inquiry or the patient's job, please contact Genevieve Hughes in Risk Management at Duquesne University at (412) 396-6677. Fax(412)396-5363. Thank you.

I examined _____ on _____ and found that (check one below)
(Print Patient's Name) (Date of Exam)

____ Patient is medically fit to perform his/her specific job at Duquesne University without restrictions and can do so without posing a direct threat to the health or safety of self or others.
Return-To-Work Date: _____.

____ Patient has been continuously unable to work from _____ to _____.
(Date of Disability) (Return-to-work Date)

This is due to a ____ Temporary ____ Permanent medical or emotional disorder.

Date of first treatment _____ Date of most recent treatment _____

Date of next treatment (visit) _____ Diagnosis _____

Why does this diagnosis prohibit employee from working? _____

____ Patient is medically fit to perform work with the following restrictions:

Restriction #1: _____
Permanent? ____ No ____ Probably ____ Definitely
If temporary, for how long? ____ Weeks/ ____ Months

Restriction #2: _____
Permanent? ____ No ____ Probably ____ Definitely
If temporary, for how long? ____ Weeks/ ____ Months

Date Employee Can Return-To-Work with Restrictions as listed: _____

If patient is pregnant, the expected due date is _____. If patient is restricted from working prior to delivery, please state reason below:

Comments: _____

Physician/Medical Provider's Name (Please Print): _____

Address _____

Phone _____ Specialty _____

Provider's Signature _____ Date _____