

NOTE: Top and bottom portions of this form must be filled out in their entirety and returned to Employee Health Services to insure continuation of salary.

# REQUEST ABSENCE FOR PERSONAL ILLNESS / ILLNESS IN FAMILY

THE SCHOOL DISTRICT OF PHILADELPHIA  
EMPLOYEE HEALTH SERVICES - SUITE 134  
440 N. BROAD STREET - PHILADELPHIA, PA 19130

◆ A NEW CARD MUST BE SUBMITTED FOR EACH PAYROLL PERIOD --- NOT TO EXCEED 10 DAYS.

◆ FAILURE TO SUBMIT CARDS MAY LEAD TO DISCIPLINARY ACTION.

◆ EMPLOYEES ON LONG-TERM ILLNESS/ILLNESS IN FAMILY MAY NOT LEAVE THE CITY WITHOUT PRIOR APPROVAL FROM EMPLOYEE HEALTH SERVICES.

## ▶ SECTION I - COMPLETED BY EMPLOYEE

Employee's Last Name	First Name	M.I.	Employee ID Number	Date
Home Address	City	State	Zip Code	Home Phone
Work Location (School/Office)	Organization No.	Position Title		
Number of Day Absent	From Date ( Month/Day/Year )	To Date ( Month/Day/Year )	Anticipated Date of Return	
Signature of Employee	Signature of Principal/Administrator		Date	

**ATTENTION: THIS COPY IS FOR VIEWING ONLY  
TO USE THIS FORM USERS MUST ORDER IT FROM  
THE WAREHOUSE.**

**=== THIS CARD DOES NOT REPLACE A MEDICAL REPORT FROM YOUR DOCTOR ===**

SEH-3 Part 1 (Rev. 3/06) Comm. Code 61602445418

## ▶ SECTION II - AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION - ALL INFORMATION WILL BE KEPT CONFIDENTIAL

**FOR EMPLOYEE ILLNESS**

I, the undersigned, authorize the release of all information regarding this illness to the Office of Employee Health Services, for which I am requesting personal illness absence

Name of Employee: \_\_\_\_\_

Employee I.D. No: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR ILLNESS IN THE FAMILY**

Name of Family Member: \_\_\_\_\_

Relationship to Employee: \_\_\_\_\_

## ▶ SECTION III - COMPLETED BY EMPLOYEE'S PHYSICIAN OR FAMILY MEMBER'S PHYSICIAN

Name of Patient: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

I certify that the above patient is / was under my professional care from (date) \_\_\_\_\_ to \_\_\_\_\_

The patient's diagnosis/diagnoses: \_\_\_\_\_

\_\_\_ Disability From Pregnancy (EDD: \_\_\_\_\_ ) Other: \_\_\_\_\_

**=== FORGERY OF PHYSICIAN'S SIGNATURE IS SUBJECT TO DISCIPLINARY ACTION ===**

Physician's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Date employee may return to work  
(Do not indicate indefinitely)

SEH-3 Part 2 (Rev. 5/11) Comm. Code 61602445418