



City of Chesapeake
Department of Human Resources
Post Office Box 15225
Chesapeake, VA 23328

Telephone: 382-6582
Fax: 382-8501

Part A - Application to Request Leave Donations

This section is to be completed by the employee.

Important: Read carefully before completing application.

To be eligible for leave donations, you must be a regular full-time or regular part-time employee, have missed a minimum of 30 workdays and exhausted all accrued leave. To apply for such benefits you must complete Part A of this application form. Part B, the Statement of Health Care Provider form is to be completed by a licensed and practicing health care provider/physician. It is your responsibility to provide the Department of Human Resources with a completed copy of Part A and Part B and any information requested. You must apply while you are still employed in a regular part-time or regular full-time permanent position. Incomplete application forms will delay the processing of your request.

Please complete and return to the Department of Human Resources.

(Please Print)

Employee's Name: _____
Last First Middle

Address: _____
Street City State Zip code

Social Security #: ____ - ____ - ____ **Date of Employment:** _____

Department Name: _____

Phone Numbers for Contact:

Position/Job Title: _____

Work: _____

Last date you worked: _____

Home: _____

Are you a Sick Leave Bank Member? Yes (or) No
If yes, how many yrs. have you been a member? _____

Payroll Clerk's Name: _____

Please answer the following questions as they relate to the duties and responsibilities of your job with the City:

Length of employment in the above type of work: _____ (yrs/mos)

1. Describe the duties of your job:

2. How does your condition now prevent you from performing this job?

3. How many days have you lost from work during the past year because of your condition? _____ Explain: _____

4. Has your condition resulted from any of the following: (Check Yes or No)

- a. Any occupationally related accident or illness from which Worker's Compensation benefits are payable. Yes No
- b. Intentionally self-inflicted injuries. Yes No
- c. Injury occurring in the course of committing a felony or assault. Yes No
- d. Service in the armed forces. Yes No
- e. War, insurrections, rebellion, or active and illegal participation in a riot. Yes No
- f. Cosmetic surgery or treatment, or surgery or treatment not deemed necessary by a Health care provider. Yes No

5. Explain fully all YES answers to questions in item 4. Identify each question by letter. Attach additional sheets if necessary.

6. Did your job at the time of your condition involve:

- a. The use of machines? Yes No
- b. Technical knowledge or special skills? Yes No
- c. Any special supervisory skills? Yes No

7. Have you filed for Worker's Compensation benefits? Yes* No

8. Have you filed a claim for Social Security benefits? Yes* No

9. Have you filed a claim for VRS Condition Retirement? Yes* No

11. Have you filed a claim for Unemployment Compensation? Yes No
If YES, on what date did you file? _____

(Month/Day/Yr)

12. Has your health care provider told you to restrict your activities in any way? Yes No

If "yes," state name of Doctor and the restrictions: _____

* NOTE: If you answered YES (to 5-8) please attach a copy of the decision.

Please list the name and address of the health care provider(s) currently or most recently treating you:

<i>Name of Health care provider</i>	<i>Name of Health care provider</i>
<i>Health care provider's Mailing Address</i>	<i>Health care provider's Mailing Address</i>
<i>Health care provider's Phone Number</i>	<i>Health care provider's Phone Number</i>
<i>How often do you see this health care provider?</i>	<i>How often do you see this health care provider?</i>
<i>Date you first saw this health care provider?</i>	<i>Date you first saw this health care provider?</i>

13. Have you been hospitalized or treated at a health care practice/facility for your condition? Yes No *If YES, please give name and address of hospital or health care practice/facility:* _____

14. Did you visit on an INPATIENT (overnight) basis? Yes No *If YES, give date of admission and date of discharge:* _____
Type of treatment received: _____

15. Did you visit on an OUTPATIENT (no-overnight) basis? Yes No *If YES, give date of visit and type of treatment received:* _____

Note: If you have been in other hospitals or health care practice/facility for your illness, list the names and addresses, dates and reasons for the hospitalization or clinic visit and the type of treatment you received:

Authorization to Release Medical Information

I hereby authorize any health care provider, hospital, agency or other organization to disclose any medical records or other information regarding my condition to the City of Chesapeake Medical Leave Review Committee.

Applicant's Signature and Date: _____

I certify that all of the information I have given in this document is true.

Applicant's Signature and Date: _____

If applicable, please list the first and last name of any relative(s) or friends that you have who also work for the City that may be willing to donated leave on your behalf :



Statement of Health Care Provider/Physician

**City of Chesapeake
Department of Human Resources
Post Office Box 15225
Chesapeake, VA 23328**

**Contact Information:
Telephone: 382-6633
Fax: 382-8501**

Part B - Application to Request Leave Donations

This section is to be completed by the employee/applicant's health care provider.

To: The Health Care Provider/Physician

The City of Chesapeake's Medical Leave Review Committee will review your report on this case to determine whether your patient is eligible to receive benefits authorized by the Committee. To speed the processing of your patient's claim, please provide the Committee with all medical information requested below.

Your complete report is key to the prompt handling of your patient's claim. Thank you for your cooperation.

Patient's Name:	Social Sec. #	Patient's Age:	Date of Patient's last examination or appointment:
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Patient History:

State the approximate date the condition commenced: _____ ***(day/mo/yr)***

Diagnosis: List any test results or disorders you have found; please be as specific as possible, stating how the disorder(s) restrict the patient:

Present Treatment:

Patient's Response to Treatment:

Was this treatment deemed medically necessary? **Yes** **No**

Part B – (cont.)

Prognosis: (The duration of condition as related to the usual duties of the patient's employment.)

Date of patient's next scheduled visit: _____

1. **In your opinion, is this patient unable to perform the usual duties of his/her employment:** Yes No

2. **If your answer to #1 above is yes, what is the projected date that this patient can return to full performance of job duties?** _____ (Mo-Day-Yr) An estimated date is required.

2a. **If applicable, would you recommend the patient apply for disability retirement?**
 Yes No Comments: _____

3. **If your answer to #1 above is no, and the patient may return to work at this time, what restrictions, if any, would the patient have upon returning to work?** _____

4. **If applicable, when can the patient return to partial performance of job duties?** _____
Mo-Day-Yr

Printed Name of Health Care Provider	Address of Health Care Provider
Health Care Provider's Signature (Date)	Health Care Provider's Contact Information
 	Telephone Number: Fax Number:

PLEASE RETURN THE COMPLETED FORM TO:

**City of Chesapeake
Department of Human Resources
Post Office Box 15225
Chesapeake, VA 23328
Fax: 382-8501**