SICK LEAVE CERTIFICATION REQUEST

MEDICAL SERVICES DIVISION

THIS FORM MUST BE COMPLETED IN ENGLISH OR FRENCH ONLY.

Please print a copy of this form for your treating health care provider. Based on your answer to question 3 and the instructions included, please request your health care provider to complete the relevant sections of the form.

Use of this form will expedite the sick leave certification process. If the form is not fully completed according to the instructions included, your sick leave certification will be delayed until all information has been submitted.

SECTION A - SUBMISSION INSTRUCTIONS

A. If this sick leave certification request WILL NOT cause you to exceed 20 certified sick leave working days, taken cumulatively or consecutively, this calendar year (i.e. you answered NO to question 3), a diagnosis is NOT required and this form should be submitted to your administrative focal point (e.g. executive officer, field personnel officer, etc).

B. If this sick leave certification request WILL cause you to exceed 20 certified sick leave working days, taken cumulatively or consecutively, this calendar year (i.e. you answered YES to question 3), a diagnosis MUST be included and this form should be submitted to the United Nations Medical Services Division:

Via e-mail to ***sickleave@un.org*** (preferred method, faster processing).
Via fax to **1-917-367-0656** (preferred method, faster processing).
Via mail to:

Attn: United Nations Medical Director
Medical Services Division, Room - S536
United Nations Secretariat
405 E. 42 St. New York, NY 10017
USA

SECTION B - TO BE COMPLETED BY THE STAFF MEMBER

1.- STAFF MEMBER INFORMATION

FAMILY NAME (IN BLOCK CAPITALS)	GIVEN NAMES

INDEX NUMBER	DATE OF BIRTH	SEX	DEPT./AGENCY, DUTY STATION (e.g DM, New York / UNDP, Copenhagen)
	____/____/____ dd mm yyyy	☐ M ☐ F	

E-MAIL ADDRESS	TELEPHONE (include country and area codes)

2.- ADMINISTRATIVE FOCAL POINT INFORMATION (executive officer, field personnel officer, etc, to be in contact with Medical Services Div. for certification purposes only)

FAMILY NAME (IN BLOCK CAPITALS)	GIVEN NAMES	E-MAIL ADDRESS	TELEPHONE

3.- Will this request cause you to exceed 20 certified sick leave working days in total (cumulatively) this calendar year? ☐ Yes ☐ No

If YES, please ensure that your treating health care provider completes Sections C, D and E. Diagnosis and Dates of Absence MUST be submitted.
If NO, please ensure that your treating health care provider completes Sections C and E. Dates of Absence MUST be submitted. Diagnosis is NOT required.
For submission instructions, please see Section A on top of this form.

4.- Is there a diagnosis included in your submission? ☐ Yes ☐ No

For submission instructions, please see Section A on top of this form.

5.- Was this sick leave taken during annual or home leave? ☐ Yes ☐ No

If yes, please state the period of annual or home leave: From ____/____/____ to ____/____/____ (dd/mm/yyyy)

6.- For DPKO and field staff only: Was this sick leave taken outside the duty station/mission area? ☐ Yes ☐ No

SECTION C - TO BE COMPLETED BY THE TREATING HEALTH CARE PROVIDER

7.- DATES OF ABSENCE

a.- DATE OF INITIAL ABSENCE	b.- DATE OF **RETURN TO NORMAL DUTIES**
An actual date MUST be provided and cannot be after the date of signature in section E.	An actual date MUST be provided. If actual sick leave absence extends beyond this date, an additional certification request must be submitted.
____/____/____ dd mm yyyy	____/____/____ dd mm yyyy

8.- DATE OF RETURN TO LIGHT DUTIES (if applicable)

_____/_____/_____

dd mm yyyy

If light duties are indicated, please describe applicable work restrictions for the above-named patient:

SECTION D - TO BE COMPLETED BY THE TREATING HEALTH CARE PROVIDER

All the information contained in this section is confidential and should be submitted only for sick leave requests over 20 days.

9.- DIAGNOSIS

10.- ICD CODE (S)

____.___

____.___

____.___

____.___

11.-TREATMENT PROVIDED (if any)

12.- WAS THE ABOVE-NAMED PATIENT HOSPITALIZED? ☐ Yes ☐ No If YES, please provide the dates and hospital location below

From: _____/_____/_____ To: _____/_____/_____

dd mm yyyy dd mm yyyy

Hospital location:

13.-PROGNOSIS (if applicable)

14.- ADDITIONAL remarks or recommendations? (particularly with reference to the type and duration of any limitations which might be necessary upon return to work)

SECTION E - TO BE COMPLETED AND SIGNED BY THE TREATING HEALTH CARE PROVIDER

15.- TREATING HEALTH CARE PROVIDER INFORMATION

PROVIDER NAME (IN BLOCK CAPITALS)

SIGNATURE: _____

E-MAIL ADDRESS

TELEPHONE

DATE: _____/_____/_____

dd mm yyyy

ADDRESS (STREET, TOWN, DISTRICT OR PROVINCE, COUNTRY)

FAX