TO BE COMPLETED ONLY FOR MEDICALLY RELATED REQUESTS

PART III: Attending Physician's Statement (please type or print legibly).

NAME: _____ Phone #: _____

Address City/State/Zip: _____

Date first consulted for this condition:_____

Briefly describe the nature, diagnosis, and treatment of illness/injury:_____
_____
_____
_____

Anticipated duration employee is unable to work due to condition or direct care of family member
From:_____ Through:_____

Signature of Physician:_____ Date:_____

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PART IV: To be completed by Colorado School of Mines Human Resources Department.

The above named employee has/will have exhausted all annual and sick leave as of _____.

Authorized Signature:_____ Date:_____

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FOR CSM PRESIDENT USE:

Application was received on: _____

DECISION: (check one) ☐ Approve ☐ Reject

Authorized Signature:_____ Date:_____

Revised 9/01/02