Sick Verification Form

The completed Sick Verification Form must be provided to the Company verifying the absence referenced below is required by the employee's illness or injury.

A. <u>This Section to be completed by the employee</u>.

Name: _____ Employee Number: _____ Base: _____

Address: _____ Phone Number: _____

Absence Begin Date: _____ Actual or Expected Return to Work Date: _____

Name of Health Care Provider (HCP) for your illness or injury: _____

I grant permission for the Company to contact my HCP indicated above for clarification: Yes _____ No _____

_____ _____
Employee Signature Date

B. <u>This Section to be completed by the HCP(s) indicated above. Only provide information for the illness or injury that gave rise to the above-referenced absence.</u>

We would like to thank you for your care and treatment of our colleague and we ask that you partner with us by completing the information below. **<u>Please type or print answers.</u>**

1) Date injury/illness began for purposes of this absence: _____

2) Is the employee able to work at this time? Yes _____ No _____

If no, what is the anticipated date for return to work? _____

3) Re-evaluation date? _____

Health Care Provider (print name): _____

Specialty/Type of Practice: _____

Phone Number: _____ Fax: _____

Health Care Provider Signature: _____ Date: _____

Ground employees - fax completed Sick Verification Form to 817-931-7540
Flight Attendants – fax completed Sick Verification Form to 817-967-1382

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