

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: _____

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: _____

FOR CSM PRESIDENT USE:

Application was received on: _____

DECISION: (check one) Approve Reject

Authorized Signature: _____ Date: _____