REQUEST FOR FAMILY OR MEDICAL LEAVE

Employee Notification

Request for Family or Medical Leave must be made in writing, if practical, at least 30 days prior to the date the requested leave is to begin.

Name Beverly VanderVelde Date 12/4/2015

School Bryant School Position Social Worker

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I request a family or medical leave for one or more of the following reasons. I understand that a physician's certification and all required information must be submitted before this request is processed.

_____ Because of the birth of my child, or because of the placement of a child with me for adoption or foster care.

_____ In order to care for my spouse/child/parent who has a serious health condition.

__✓__ For a serious health condition that makes me unable to perform my job. THIS CONDITION ____ IS __✓__ IS NOT WORK RELATED.

_____ Requested intermittent or reduced leave scheduled ____________________

Leave to start 1/4/16 Expected return date 6/30/16

_____ I would like to use my sick/personal days

_____ I would not like to use my sick/personal days

_____ Original request for leave

__✓__ Request for extended leave

Employee Signature B J VanderVelde Date 12/4/2015

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LEAVE APPROVAL

Principal/Designee Signature [signature] Date 12.9.15

Superintendent Signature [signature] Date 12/10/15

Board Secretary Signature ______________________ Date __________

Board President Signature ______________________ Date __________

TEACHERS' RETIREMENT SYSTEM OF THE STATE OF ILLINOIS
2815 W Washington, PO Box 19253
Springfield IL 62794-9253
(800)877-7896, FAX: (217)753-0964
TDD: (866)326-0087
members@trs.illinois.gov
http://trs.illinois.gov

Physician's Certification of Disability

A member of the Teachers' Retirement System of the State of Illinois (TRS) is eligible for a disability benefit if he or she is found by medical examination to be incapacitated to perform the duties of his or her position as a teacher. A member is also eligible if he or she becomes totally and immediately incapacitated for duty as the result of bodily injuries sustained while in the performance and within the scope of his or her duties.

This certification and supporting clinical evidence will be reviewed by the TRS Disability Department. The member is responsible for any fee involved with the completion of this form, unless other payment has been arranged.

Complete and send this original form to TRS. Please include copies of clinical notes and all pertinent test results. Copies of treatment notes from the last 12 months must accompany this form. All documents are confidential at TRS.

Beverly J Vander Velde	File number:	**0158 35338**
2241 Sunnyside Ave	Date of birth:	**04/02/1947**
	Home telephone number:	**(708) 562-4420**
Westchester IL 60154-5223	Work telephone number:	**(708) 333-~~0478~~** D300
	Work extension number:	**24**

Although the decision regarding eligibility for disability benefits rests with the TRS Disability Department, in your professional opinion does the patient's condition clearly come within the eligibility requirements stated above?

☑ Yes ☐ No If "no," explain. ______

Diagnosis (include ICD codes)	AHA/AMA classification; grade or stage of malignancy	Prognosis	
		Short term	Long term
RIGHT DISTAL HUMERUS PATHOLOGIC FX			
M84.429A			

History of symptoms, accidents, surgeries, and referrals *(Please enclose treatment notes.)*

ALL NOTES ATTACHED

Present function limitations 5 POUND WEIGHT RESTRICTION FOR RIGHT ARM
REMAIN OFF WORK

Date of first visit	Date of most recent visit	Frequency of visits during the past year
7-20-15	11-25-15	☐ Weekly ☑ Monthly ☐ Annually ☑ Other (explain) PRN

Date the patient became unable to work	Has the impairment been continuous since the date the patient became unable to work?
7-24-15	☑ Yes ☐ No

Hospitalizations *(Please send discharge summaries.)*

Name of hospital	Admission date	Discharge date	Discharge diagnosis
CHRIST HOSPITAL	OUT PATIENT	SURGERY	

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ds