

**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 Lynda T. Reese Date January 18, 2017  
7th grade

School Brooks Position Social Studies Teacher

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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.

X For a serious health condition that makes me unable to perform my job. THIS CONDITION \_\_\_\_\_ IS X IS NOT WORK RELATED.

\_\_\_\_\_ Requested intermittent or reduced leave scheduled \_\_\_\_\_

Leave to start 3 / 15 / 2017 Expected return date 7 / 13 / 2017

- X I would like to use my sick/personal days
- \_\_\_\_\_ I would not like to use my sick/personal days
- X Original request for leave
- \_\_\_\_\_ Request for extended leave

Employee Signature Lynda T. Reese Date January 18, 2017

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**LEAVE APPROVAL**

Principal/Designee Signature [Signature] Date 1-18-17

Superintendent Signature [Signature] Date 1/27/2017

Board Secretary Signature \_\_\_\_\_ Date \_\_\_\_\_

Board President Signature \_\_\_\_\_ Date \_\_\_\_\_

Sick Days - 167

**JOHN D. SONNENBERG, M.D.**  
**D. DIRK NELSON, M.D.**  
**MICHAEL G. MADAY, M.D.**  
**STEPHEN V. PERNS, D.P.M.**  
**WILLIAM A. HELLER, M.D.**  
**JAY M. BROOKER, M.D.**  
**ROBERT J. STRUGALA, M.D.**  
**TELLY PSARADELLIS, M.D.**  
**GERALD F. LOFTUS, M.D. (emeritus)**



2850 S. WABASH SUITE 100  
 CHICAGO, IL 60616  
 312/842-4600

8735 S. MERRION LANE  
 HOMETOWN, IL 60456  
 708/425-1150

5201 S. WILLOW SPRINGS RD., #340  
 LA GRANGE, IL 60525  
 708/482-7767

9717 S. WESTERN AVE.  
 CHICAGO, IL 60643  
 773/239-5495

OFFICE VISIT (NEW)	CODE	FEE	CASTING	CODE	FEE	OTHER SERVICES	CODE	FEE
LEVEL	9920		LONG ARM	29065		ASPIRATION SMALL-R/L	20600	
EMERGENCY	99058		SHORT ARM	29075		ASPIRATION LARGE-R/L	20610	
<b>OFFICE VISIT (established)</b>			LONG LEG	29355		TRIGGER POINT-R/L	20550	
LEVEL	9921		SHORT LEG	29425		CELESTONE ___ CC	J0704	
COMPLICATING	(9921)-24		PLASTER(#ROLLS___)	A4580		DEBRIDEMENT	11040	
SURGICAL FOLLOW-UP	99024		FIBERGLASS(#ROLLS___)	A4590		PIN REMOVAL	20670	
<b>CONSULTATIONS DR.</b>			UNNA BOOT	29580		SPECIAL REPORTS	99080	
LEVEL	9924		FINGER SPLINT	29130		FRACTURE CARE ( )		
LEVEL	9927		<b>MISC.</b>			( )		
IME	99456					OTHER ( )		
						SUPPLIES ( )		

DIAGNOSIS: ( ) \_\_\_\_\_

DATE OF INJURY \_\_\_\_\_ FIRST CONSULT \_\_\_\_\_

RETURN TO WORK:

( ) NOT YET; ESTIMATED RETURN \_\_\_\_\_

( ) LIGHT DUTY ONLY AS OF \_\_\_\_\_

RESTRICTIONS: \_\_\_\_\_

M170 BILATERAL PRIM OSTEOARTHRITIS KNEE

PCP - Lubin - Johnson

SURGERY: ( ) SD ( ) AM DATE: \_\_\_\_\_

OPERATION: \_\_\_\_\_

Wednesday March 15, 201

SURGERY - Mercy  
(R) TKR

PDC-LEVEL \_\_\_\_\_ MMI AS OF \_\_\_\_\_

( ) REGULAR DUTY; NO RESTRICTIONS AS OF \_\_\_\_\_

ANESTHESIA: \_\_\_\_\_ ( ) BRQ ( ) CLR ( ) EPT

X \_\_\_\_\_  
 DOCTOR'S SIGNATURE

NEXT APPOINTMENT: \_\_\_\_\_ D \_\_\_\_\_ W \_\_\_\_\_ M \_\_\_\_\_ AS NEEDED  
 DATE: \_\_\_\_\_ DAY: \_\_\_\_\_ TIME: \_\_\_\_\_

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID TO THE ABOVE SIGNED PHYSICIAN, REALIZING I AM RESPONSIBLE TO PAY NON-COVERED SERVICES AND I HEREBY AUTHORIZE THE RELEASE OF PERTINENT MEDICAL INFORMATION TO INSURANCE CARRIERS.

X Lynda J. Reese DATE 1-17-17 new referral next visit

**ACCOUNT INFORMATION**

**PATIENT INFORMATION**

Discuss Sx  
per DMW  
2012  
 FROM DATE: \_\_\_\_\_ THRU DATE: \_\_\_\_\_

DATE	TIME	PATIENT	SEX: M F	PRIOR BALANCE
01/17/17	3:45P	LYNDA REESE	F	312.27
CHRG. SLIP NO.	DOCTOR	LOCATION	TODAY'S CHARGES	
1360178	TELLY PSARADELLIS MD	HOMETOWN OFFICE		
ACCT.NO.	RESPONSIBLE PARTY	PHONE NO.	TODAY'S PAYMENT	
112094	LYNDA	708 / 339-0649	\$50.00	
RECAP:	OVER 90	OVER 60	OVER 30	CURRENT
	.00	.00	.00	.00
INSURANCE COMPANY	POLICY NUMBER	BALANCE TYPE	BALANCE DUE	
MPBA	XOH845702 / B56884	F	ck# 1434	
			xmk	

REFERRAL COPY \$50.00