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 J. VANDERVELDE Date 7-14-15

School BRYANT / SANDBURG 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.

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 08/03/15 Expected return date 01/04/16

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 Beverly Vander Velde Date 7-14-15

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LEAVE APPROVAL

Principal/Designee Signature _____ Date 8/4/15

Superintendent Signature _____ Date 8/6/15

Board Secretary Signature _____ Date _____

Board President Signature _____ Date _____

07-20-15P03:37 RCVD

Clinical Findings *(Please send chart notes and consultative reports.)*

Please report all pertinent findings with dates. Attach laboratory studies, hospital discharge summaries, quantitative measures with "normal values," and interpretation of record.

Height (without shoes)	Present weight (pounds - without shoes)	Date of findings
5'4.5"	122#	7/20/15

Best corrected visual acuity NA OD _____ OS _____ OU Date _____

If visual fields have been done, please provide findings and attach chart.

B.P. 130/70 Date 7/20/15 Does the patient have hypertension or hypotension? ☑ Yes ☐ No

Have any current tests been done? ☑ Yes ☐ No

If "yes," please send copies of the **written** test reports (*e.g.,* myelogram, treadmill, Dopplers, lab studies, CT scans, MRI, X-rays, pathology). ***Do not send original X-rays.***

Course of treatment and patient response (*e.g.,* inclusive dates, referrals, medication, compliance, surgical interventions, radiation/physical therapy, and special diet). ***(Please enclose treatment notes.)*** Surgery 7/24/15 for Pathologic Fracture (R) arm - Radiation + Chemotherapy planned

Impairment

Physical impairment	Mental impairment	Type of impairment
☒ Yes ☐ No	☐ Yes ☒ No	☒ Temporary ☐ Permanent ☐ Terminal

Function	Degree of impairment			
	None	Mild	Moderate	Severe
Cognitive ability	✓			
Mental status	✓			
Hearing	✓			
Vision		✓		
Speaking	✓			
Respiration		✓		
Bending		✓		
Handling/Fingering			✓	
Reaching			✓	
Stamina (fatigue)			✓	
Pain factor			✓	
Other				

Estimate **future** duration of patient's impairment.

☑ 0 - 6 months
☐ 7 - 11 months
☐ 12 months or more

Date patient will return to work, if known Jan 4, 2016

Aids/Therapy

Prescribed self-accommodation aids (Check appropriate boxes.)

☐ Brace ☐ Cane ☐ Crutches ☐ Hearing aids ☐ Prosthesis
☐ Visual acuity aid ☐ Walker ☐ Wheelchair ☐ Other (specify) _____

Describe other aids the patient could use to improve functioning. _____

Physician's Certification of Disability (cont.)

Name	File number	Claim number
Beverly J Vander Velde	**0158 35338**	**755123**

Is the patient able to perform present teaching employment or any other full-time employment while undergoing treatment or therapy for this impairment? ☐ Yes ☒ No

If "yes," check the appropriate box and explain. ☐ Without restriction ☐ Semi-sedentary ☐ Sedentary

Type of employment patient may perform _____

If the patient's psychiatric or medical condition is amenable to ongoing therapy and treatment under a prescribed treatment program, please explain and indicate how often treatment or therapy should be instituted per month to achieve improvement. ***(Please enclose treatment notes.)*** She will be getting on going treatment.

Additional Information

Describe any other impairments or medical conditions not included on this form

For pregnancy only

LMP _____ EDC _____

Additional comments _____

Would you discuss this case with TRS staff by telephone if necessary? ☐ Yes ☐ No

If "yes," what days and times are you available for telephone calls? _____

Certification: I certify that I am a licensed practicing physician (MD). By signing, I certify that this information is correct. I am aware that pursuant to the Illinois Pension Code, 40 ILCS 5/1-135, any person who knowingly makes any false statement or falsifies or permits to be falsified any record in an attempt to defraud the Teachers' Retirement System is guilty of a Class 3 felony. Please be advised that if the TRS Board has a reasonable suspicion that a false record has been filed with the System, it is required to report the matter to the appropriate state's attorney for investigation.

Name (print or type)	Address	
DAVID STEWART MD	7400 W. 111th ST STE 210	
License number	City, state, ZIP	
036-070272 (ILLINOIS)	WORTH IL 60482	
Medical specialty		
FAMILY MEDICINE		
Board certified ☒ Yes Date certified 1985 ☐ No	Telephone number (708) 660-3200	Fax (708) 923 9818
Physician signature (A stamped signature cannot be accepted.)		Date 9/28/15