

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. VANDERVELSE Date 7-14-15

School BRYANT (SANDBURG) Position SOCIAL WORKER

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 Vandersel Date 7-14-15

LEAVE APPROVAL

Principal/Designee Signature [Signature] Date 8/4/15

Superintendent Signature [Signature] Date 8/6/15

Board Secretary Signature Date

Board President Signature Date

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) <u>5'4.5"</u>	Present weight (pounds - without shoes) <u>222#</u>	Date of findings <u>7/20/15</u>
Best corrected visual acuity <u>NA</u> OD _____ OS _____ OU _____ Date _____		
If visual fields have been done, please provide findings and attach chart.		
B.P. <u>130/70</u> Date <u>7/20/15</u> Does the patient have hypertension or hypotension? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
Have any current tests been done? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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.) <u>Surgery 7/24/15 for Pathologic Fracture (R) arm - Radiation + Chemotherapy planned</u>		

Impairment

Physical impairment <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Mental impairment <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Type of impairment <input checked="" type="checkbox"/> Temporary <input type="checkbox"/> Permanent <input type="checkbox"/> Terminal
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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.)

<input type="checkbox"/> Brace	<input type="checkbox"/> Cane	<input type="checkbox"/> Crutches	<input type="checkbox"/> Hearing aids	<input type="checkbox"/> Prosthesis
<input type="checkbox"/> Visual acuity aid	<input type="checkbox"/> Walker	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Other (specify) _____	

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

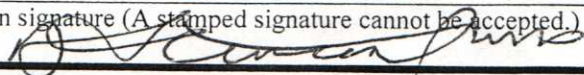
Physician's Certification of Disability (cont.)

Name Beverly J Vander Velde	File number 0158 35338	Claim number 755123
Is the patient able to perform present teaching employment or any other full-time employment while undergoing treatment or therapy for this impairment? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
If "yes," check the appropriate box and explain. <input type="checkbox"/> Without restriction <input type="checkbox"/> Semi-sedentary <input type="checkbox"/> 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. <i>(Please enclose treatment notes.)</i> <u>She will be getting on going treatment.</u>		

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? <input type="checkbox"/> Yes <input type="checkbox"/> 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) DAVID STEWART MD	Address 7000 W. 111th ST STE 210	
License number 036-070272 (ILLINOIS)	City, state, ZIP WORTH IL 60482	
Medical specialty FAMILY MEDICINE		
Board certified <input checked="" type="checkbox"/> Yes Date certified 1985 <input type="checkbox"/> No	Telephone number (708) 660-3200	Fax (708) 923 9818
Physician signature (A stamped signature cannot be accepted.) 		Date 1/28/15