

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 Calvin Horne Date 10/24/17

School Brooks Middle School Position Custodian

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 11/10/17 Expected return date DEC 10/1/17

☐ 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 Cal Horne Date 10/24/17

LEAVE APPROVAL

Principal/Designee Signature _____ Date _____

Superintendent Signature Ali Margolis Date 10.24.17

Board Secretary Signature _____ Date _____

Board President Signature _____ Date _____

PHYSICAL / OCCUPATIONAL THERAPY ORDER

Order Date: 10/17/2017

To Provider	From Provider
Phone: Fax:	DIMPAL PATEL, PA MIDWEST ORTHOPAEDICS AT RUSH LLC 1611 West Harrison Street Suite 400 Chicago, IL 60612-4861 Phone: (877) 632-6637 Fax: (708) 409-5179

PATIENT INFORMATION

Patient Name	HORNE, CALVIN
Sex - DOB - Age	M 04/26/1964 53yo
Address	1116 E 160TH PL SOUTH HOLLAND, IL 60473-1718
Phone	H: (708) 333-6120 W: (708) 333-0300 M: (708) 533-6902
Primary Insurance	BCBS-IL (PPO) ID: PAS847334047 Group: 099562 Policy Holder: HORNE, DEBORAH J
Secondary Insurance	None recorded.

PT/OT ORDER INFORMATION


Diagnosis	Crushing injury of finger - Right ICD-10: S67.90XA: Crushing injury of unspecified part(s) of unspecified wrist, hand and fingers, initial encounter
Order Name	CERTIFIED HAND THERAPIST REFERRAL
Physician Specific Orders	

Orders included: 1

- CERTIFIED HAND THERAPIST REFERRAL
Schedule Within: provider's discretion
Note to Provider:
Please call if you have any questions. 312-432-2346.
Refer Occupational therapy / certified hand therapy for Eval and Treat

Reason for Referral: 08/10/2017 - R IF I&D, partial amputation, skin closure
Exercises: AROM / PROM. Progress to gentle isometrics and gentle strengthening as tolerated.
Modalities: prn, per therapist
Number of Weeks: 6
Precautions/Limitations: High repetition, low weight exercises
Visits per Week: 2-3

Electronically Signed by: DIMPAL PATEL, PA, PA-C



This order expires 30 days from the date of issue.

** Please FAX a copy of patient report to (708) 409-5179 at least 3 days prior to patient appointment. **

The physicians of Midwest Orthopaedics at Rush and the therapists at Midwest Orthopaedics Physical Therapy and Occupational Therapy are financially integrated. If you are referred for therapy services you may request and receive a referral for these services outside of or independent of Midwest Orthopaedics at Rush.