EMPLOYEE'S REQUEST TO LEAVE WORK

(FOR A DOCTOR'S APPOINTMENT)

TO ____ Date ____________________

Please be advised that may patient, ____
has an appointment in my office for: NAME OF YOUR EMPLOYEE

☐ A work-related injury ☐ A work-related illness

☐ Other ____

Date of Employee's injury/illness ______________________ Claim No. ____________________

Date Employee first reported to you ____

THE PATIENT'S TREATMENT SCHEDULE IS AS FOLLOWS:

Date ______________ Time __________ Estimated time of treatment ______________

Date ______________ Time __________ Estimated time of treatment ______________

Date ______________ Time __________ Estimated time of treatment ______________

Date ______________ Time __________ Estimated time of treatment ______________

Signature ____ I.D. No. ____________________
DOCTOR/HEALTH CARE PROVIDER

Address ____ Phone ____________________

#64-N

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SAMPLE