NEW YORK CITY DEPARTMENT OF EDUCATION

RCS PA8C185

DIVISION OF HUMAN RESOURCES – MEDICAL DIVISION
65 COURT STREET – BROOKLYN, NEW YORK 11201

CONFIDENTIAL MEDICAL REPORT AND MEDICAL EVALUATION

( ) - Community District ( ) - City District Instructional Staff

(Please type or print. See Rules and Instructions on reverse side of last copy.)

I. TO BE COMPLETED BY APPLICANT OR SCHOOL SECRETARY:

MR.
MISS
MRS. _____
(LAST NAME) (FIRST NAME) (INITIAL)

MAIDEN OR OTHER
LAST NAME USED _____

FILE NO. _____ SOCIAL SEC. NO. _____

( ) - REGULARY APPOINTED
( ) - REGULAR SUBSTITUTE
( ) - PER DIEM SUSTITUTE

YEARS OF SERVICE

LICENSE _____

HOME ADDRESS _____ ZIP CODE _____

HOME TELEPHONE _____ BIRTHDATE _____

SCHOOL _____ BOROUGH _____ DISTRICT _____

PLEASE CHECK PURPOSE IN CONNECTION WITH WHICH SUBMITTED AND SUPPLY ALL DATA CALLED FOR

( ) **A** - EXCUSE OF ABSENCE OF MORE THAN TWENTY DAYS FOR PERSONAL ILLNESS (SICK LEAVE)

INITIAL DATE OF CURRENT ABSENCE _____

(APPLICATION FORM OP 198 MUST ALSO BE SUBMITTED THROUGH PRINCIPAL.)

( ) **B** - EXCUSE OF ABSENCE FOR ALLEGED ACCIDENT IN LINE OF DUTY

FROM _____ TO _____

(APPLICATION FORM OP 198, REPORT OF INJURY TO MEMBER OF PROFESSIONAL STAFF, AND ASSIGNMENT FORM OP 200 MUST ALSO BE SUBMITTED THROUGH PRINCIPAL.)

( ) **C** - SABBATICAL LEAVE OF ABSENCE . . . FOR RESTORATION OF HEALTH

FROM _____ TO _____

(APPLICATION FORM OP 8 MUST ALSO BE SUBMITTED THROUGH PRINCIPAL. LIST ALL PRIOR SABBATICALS AND LEAVES OF ABSENCE WITHOUT PAY BELOW WITH DATES AND PURPOSE OF EACH.)

( ) **D** - LEAVE OF ABSENCE WITHOUT PAY . . . FOR RESTORATION OF HEALTH

FROM _____ TO _____

(APPLICATION FORM OP 160 MUST ALSO BE SUBMITTED THROUGH PRINCIPAL. LIST ALL PRIOR LEAVES OF ABSENCE WITHOUT PAY AND SABBATICALS WITH DATES AND PURPOSE OF EACH BELOW.)

( ) **E** - OTHER

LIST DATES AND PURPOSE OF ALL PRIOR SABBATICAL LEAVES:

LIST DATES AND PURPOSE OF ALL PRIOR LEAVES WITHOUT PAY:

II. TO BE COMPLETED BY ATTENDING PHYSICIAN AND MAILED DIRECTLY TO MEDICAL DIVISION

CONFIDENTIAL AND STRICTLY PRIVILEGED MEDICAL REPORT

TECHNICAL DIAGNOSIS _____

PROBABLE DATE OF RETURN (WHEN APPLICANT WILL BE ABLE TO PERFORM DUTIES) _____

ADDITIONAL CLINICAL DETAILS (PARTICULARLY NECESSARY WHEN ABSENCE IS PROLONGED OR COMPLICATIONS ENSUE):

IN SURGICAL CASE:

NATURE OF OPERATION _____ DATE OF OPERATION _____

DATE _____ SIGNATURE OF ATTENDING PHYSICIAN _____, M.D.

PRINTED OR TYPED NAME OF PHYSICIAN _____

PHYSICIAN'S ADDRESS _____ TELEPHONE NO. _____

COPY 1-FOR MEDICAL DIVISION ONLY