NEW YORK STATE | Department of Civil Service

EMPLOYEE HEALTH SERVICE
Agency Request for Medical Examination

EHS-707 (9/2024)

(518) 233-3100 General Information ReturnToWorkRequest@cs.ny.gov

PERSON REQUESTING EXAMINATION

Print Name	*Signature*	*Date of Request*

Title	*Phone Number*	*Fax Number*

Agency Name and Address

Agency Code	*Division*	*Preferred Service Location*

Name of Agency Payment Coordinator:

Address	*Phone Number*

Name of Contact Person to Schedule Appointment	*Phone Number*

INFORMATION CONCERNING:

Employee's Name	*S.S. #*	*Date of Birth*

Street Address

City	*State*	*Zip Code*

Employee's Agency	*Employee's Title*

INDICATE LEGAL AUTHORITY FOR REQUEST (See Section 2620 of the State Personnel Management Manual for information that is required to be submitted. The explanation, which should be attached, must include official job description, task assignments, and any reasonable accommodations whether pending or provided.)

- ☐ Involuntary Leave (CSL 72)
- ☐ ADA
- ☐ Return to Work From:
  - ☐ Involuntary Leave (CSL 72)
  - ☐ Personal Illness (4 NYCRR 21.3 (e) or 28-1.3 (e))
  - ☐ Workers' Comp. (4 NYCRR 5.9)
- ☐ Reinstatement
  - ☐ Workers' Compensation (CSL 71 and 4 NYCRR 5.9)
  - ☐ Ordinary Leave (CSL 73)
- ☐ Workers' Comp. (4 NYCRR 21.8 (i) or 28.1.8 (n))
- ☐ Approval to Charge Absence for Personal Illness (4 NYCRR 21.3 (d) or 28-1.3 (d))
- ☐ Other (specify):

PLEASE DO NOT WRITE ON THE REVERSE SIDE OF THIS FORM.