



(518) 233-3100 General Information

(518) 233-3131 Fax

PERSON REQUESTING EXAMINATION

<i>Print Name</i>		<i>Signature</i>		<i>Date of Request</i>
<i>Title</i>		<i>Phone Number</i>	<i>Fax Number</i>	
<i>Agency Name and Address</i>				
<i>Agency Code</i>	<i>Division</i>		<i>Preferred Service Location</i>	
<i>Name of Agency Payment Coordinator:</i>				
<i>Address</i>			<i>Phone Number</i>	
<i>Name of Contact Person to Schedule Appointment</i>			<i>Phone Number</i>	

INFORMATION CONCERNING:

<i>Employee's Name</i>		<i>S.S. #</i>	<i>Date of Birth</i>	
<i>Street Address</i>				
<i>City</i>			<i>State</i>	<i>Zip Code</i>
<i>Employee's Agency</i>			<i>Employee's Title</i>	

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 and task assignments.)

<input type="checkbox"/> Involuntary Leave (CSL 72) <input type="checkbox"/> ADA <input type="checkbox"/> Return to Work From: <input type="checkbox"/> Involuntary Leave (CSL 72) <input type="checkbox"/> Personal Illness (4 NYCRR 21.3 (e) or 28-1.3 (e)) <input type="checkbox"/> Workers' Comp. (4 NYCRR 5.9)	<input type="checkbox"/> Reinstatement <input type="checkbox"/> Workers' Compensation(CSL 71 and 4 NYCRR 5.9) <input type="checkbox"/> Ordinary Leave (CSL 73) <input type="checkbox"/> CSL 55-b/c <input type="checkbox"/> Workers' Comp. (4 NYCRR 21.8 (i) or 28.1.8 (n)) <input type="checkbox"/> Approval to Charge Absence for Personal Illness (4 NYCRR 21.3 (d) or 28-1.3 (d))
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Other (specify):

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