THE CITY OF NEW YORK
DEPARTMENT OF CORRECTION

DIRECTIVE

[ ] NEW	[ ] INTERIM	[X] REVISED	SUBJECT
EFFECTIVE DATE 02/14/00		*TERMINATION DATE / /	ABSENCE CONTROL/ UNIFORMED SICK LEAVE POLICY

CLASSIFICATION	SUPERSEDES	DATED	DISTRIBUTION	PAGE 1 OF 7 PAGES
#2258R-A	Directive #2258R	04/12/93	A	

RECOMMENDED FOR APPROVAL BY REVIEW BOARD MEMBER	AUTHORIZED BY THE COMMISSIONER
WILLIAM J. FRASER, CHIEF OF DEPARTMENT SIGNATURE	BERNARD B. KERIK SIGNATURE

I. PURPOSE

To establish an Absence Control Program to reduce chronic absenteeism among members of the uniformed force.

II. POLICY

To maximize the efficiency of the uniformed force by identifying and monitoring members who may require special attention and counseling concerning their use of sick leave.

Note: For the purpose of this Directive, the following shall be excluded in the calculation of use of sick leave:

A. absences while confined to an admitting hospital;

B. the first absence (occurrence) resulting from a line of duty injury which was the result of an:

1. Unusual Incident, as defined in Directive 5000R, resulting in a serious injury;

2. Injuries sustained as a direct result of a Use of Force incident (any subsequent absences resulting from the UOF incident once a member has returned to duty will be considered in the calculation of sick leave);

C. absence related to pregnancy, subject to such limitations as the Department imposes.

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III. PROCEDURE

A. CHRONIC ABSENCE

1. A member who reports sick on twelve (12) or more work days within a twelve (12) month period shall be classified as chronic absent and notified in writing of the classification (See Attachment A, Designation as Chronic Absent, form #2258-A).

2. A chronic absent classification shall remain in effect for six (6) months from the date the member returns to duty after being absent twelve (12) or more work days.

3. If the member is not absent during the six (6) month period the chronic absent classification shall be removed.

4. If the member is absent during the six (6) month period, the chronic absent classification shall be extended for six (6) months following the date the member returns to duty following the last absence.

5. A member classified as chronic absent may appeal that classification in accordance with the appeal procedures established in this Directive.

B. APPEAL PROCEDURE

1. A member classified as chronic absent may file a written appeal any time within twenty (20) days following the day the member receives written notification of the classification. The appeal shall be directed to the member's Commanding Officer and shall specify the reasons why the member believes the classification should be removed. The appeal may include any documentary evidence or exhibits the member believes will be helpful in resolving the appeal.

2. a. Upon receipt of the member's appeal, the Commanding Officer or a designee shall consider the facts and circumstances surrounding the member's absences as well as the reasons specified by the member. Factors to be considered include:

   i. The member's use of sick leave since joining the Department;

   ii. Whether the sick leave is the result of a verified line-of-duty injury, pregnancy or hospitalization;

   iii. Whether the use of sick leave precedes or follows pass days and holidays;

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III. PROCEDURE (cont.)

iv. Whether the use of sick leave is associated with ordered overtime or lost pass days;

v. The nature of the illness/injury (The Health Management Division (HMD) will verify nature of illness upon request).

b. The Commanding Officer or designee shall state their reasons for recommending the approval or denial of the appeal in writing and forward all documents to the Bureau/Assistant Chief of the Division and/or the Deputy Commissioner of the unit.

3. The Bureau/Assistant Chief of the Division and/or the Deputy Commissioner of the unit shall review the recommendation and note their determination, either affirming or reversing the Commands recommendation. The review shall be forwarded to HMD for recommendation.

4. The Commanding Officer of Health Management Division shall review appropriate records and render a final recommendation of the appeal.

5. The appeal will then be forwarded to the Bureau Chief of Administration for final determination.

6. Any member whose appeal is granted shall be immediately removed from the chronic absent classification. If following the next sick report the member meets the criteria for placement in the chronic absent classification, placement shall be made in accordance with the aforementioned procedures.

C. DISCRETIONARY BENEFITS AND PRIVILEGES

Discretionary benefits and privileges include but are not limited to:

1. Assignment to a steady tour;
2. Assignment to a specified post or duties;
3. Access to voluntary overtime;
4. Promotions;
5. Secondary employment;

III. PROCEDURE (cont.)

6. Assignment to preferential/special units or commands;

7. Transfers.

D. DISCIPLINARY SANCTIONS

In addition to the loss of discretionary benefits and privileges, a member who reports sick for twelve (12) or more work days during a twelve (12) month period may be subject to disciplinary sanctions.

E. TERMINATION

1. A member who reports sick forty (40) or more work days within a twelve (12) month period may be subjected to termination.

2. A member who reports sick on fifteen (15) or more occasions within a twelve (12) month period may be subject to termination.

F. MITIGATION

Before a disciplinary or termination action is commenced, the following mitigating factors shall be considered:

1. The member's use of sick leave since joining the Department;

2. Whether the sick leave is the result of a line of duty injury which was the result of an Unusual Incident (Directive 5000R) or a Use of Force Incident (Directives 5005R/5006);

3. Whether the use of sick leave precedes or follows pass days and holidays;

4. Whether the use of sick leave is associated with ordered overtime; and

5. The nature of the illness.

G. ADMINISTRATIVE PROCEDURES

1. It is the responsibility of each Commanding Officer or designee to monitor the attendance records of the members assigned to that command and to counsel any member whose record is developing a pattern that will result in a chronic

III. PROCEDURE (cont.)

absent classification (Refer to Attachment B, Attendance Counseling, form #2258-B). However, the lack of counseling will not negate the member from entering into a chronic absent classification.

2. The Commanding Officer may deny or revoke one (1) or more discretionary benefits and privileges of a member who despite counseling developed a pattern that evidences an abuse of sick leave. The member shall have five (5) days in which to appeal such revocation. The Commanding Officer shall forward the appeal to the respective Bureau/Assistant Chief for final review and determination. The determination shall be returned to the member's Command within two (2) business days of receipt. The member shall be advised of the determination and a copy of the review shall be placed in the employee's personal history folder.

3. A member placed into a chronic absence designation, may suffer the denial or revocation of one or more discretionary benefits and privileges at the discretion of the Commanding Officer anytime after the twenty (20) day appeal period has expired. If a member has filed a timely appeal, no denial or revocation of discretionary benefits shall take effect pending the determination of the appeal.

4. The denial or revocation of one or more discretionary benefits and privileges shall not be automatic. Before such a determination is made consideration shall be given to the following factors:

   a. The member's use of sick leave since joining the Department;

   b. Whether the sick leave is the result of a verified line-of-duty injury, pregnancy or hospitalization;

   c. Whether the use of sick leave precedes or follows pass days and holidays;

   d. Whether the use of sick leave precedes or follows ordered overtime or lost pass days;

   e. The nature of the illness; and

   f. The employee's work performance.

III. PROCEDURE (cont.)

Members classified as chronic absent shall be given the highest priority for home visits by the Department's representatives. The member shall again be eligible for discretionary benefits and privileges upon the member's removal from the chronic absent classification.

H. DUTIES AND RESPONSIBILITIES OF THE HEALTH MANAGEMENT DIVISION

1. The Health Management Division shall provide medical service for all members of the Department.

2. The Health Management Division will also provide verification of nature of illness when a member submits an appeal using his/her illness as a basis.

Location: Health Management Division
One Lefrak City Plaza - 15th Floor
59-17 Junction Boulevard
Rego Park, New York 11368
(718) 595-2524/2542

I. EMPLOYEE RESPONSIBILITIES

No employee who has a chronic absent classification, shall be permitted to return to duty without authorization from the Health Management Division.

1. Such members scheduled to work the 8-4 tour, who report sick shall report in person to the Health Management Division no later than 1100 hours on the day the member reports sick.

2. Such members scheduled to work the 4-12 tour who reported sick shall report in person to the Health Management Division no later than 1700 hours on the day the member reports sick.

3. Such members scheduled to work the 12-8 tour, who reported sick shall report to the Health Management Division in person by 0700 hours, on the first day of absence.

4. In the event that such member is too ill to report to the Health Management Division on the first day of absence, said member shall notify the Health Management Division by telephone, at (718) 595-2524/2542. Additionally, the member shall obtain a doctor's note from his/her personal physician or hospital, stating the following:

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III. PROCEDURE (cont.)

a. Diagnosis;

b. Treatment;

c. Prognosis (including anticipated date of return to duty).

The above information shall be written in non-medical terminology and shall be submitted to the Health Management Division, confirming that the condition was severe enough to prevent the member from reporting to the Health Management Division on the first day of absence.

IV. REFERENCES

A. Directive #5000R, REPORTING UNUSUAL INCIDENTS, dated 04/13/92 (as amended).

B. Directive #5005R, USE OF FORCE (C.I.F.M. ONLY), dated 01/25/99.

C. Directive #5006, USE OF FORCE (ALL FACILITIES EXCLUDING C.I.F.M.), dated 01/25/99.

V. ATTACHMENTS

A. Designation as Chronic Absent, Form #2258-A

B. Attendance Counseling, Form #2258-B

C. Medical Documentation Form (Form HM 1-87)

VI. SUPERSEDES

Directive #2258R, ABSENCE CONTROL/UNIFORMED SICK LEAVE PROGRAM, dated 04/12/93.

Form #2258-A

600AR

DEPARTMENT OF CORRECTION – INTERDEPARMENTAL MEMORANDUM

DATE :

TO :

FROM :

SUBJECT : Designation As Chronic Absent

1. You have been designated as Chronic Absent. This designation shall remain in effect for a minimum of six (6) months from ___________.
   Date

2. This designation shall be removed if you do not report sick during the next six (6) months. Admission to and confinement in a hospital and the first absence (occurrence) resulting from a line six of duty injury which was the result of an Unusual Incident or a Use of Force Incident, shall be excluded.

3. This designation shall be extended for an additional six (6) months if you report sick (except for admission to and confinement in a hospital and the first absence [occurrence] resulting form a line of duty injury which was the result of an Unusual Incident or Use of Force Incident) during the next six (6) months.

4. You may appeal this determination by following the procedures specified in Directive 2258R-A in Section III. B.

5. As a result of being classified as chronic absent, you are subject to the denial or revocation of one (1) or more of the discretionary benefits and privileges specified in Directive #2258R-A in Section III. C.

   a. The determination to deny or revoke one (1) or more discretionary benefits and privileges is not made automatically. The Chief of Administration shall review the facts and circumstances surrounding the absences and consider the factors specified in Directive #2258R-A Section III. B. 2. You will be notified of that determination.

   b. Whenever you are reporting sick, while designated Chronic Absent, you are directed to report in person to the Health Management Division as per the following schedule:

6. If the absence occurs on a scheduled 8 x 4 tour, you are to report no later than 1100 hours on the first day of absence.

   a. If the absence occurs on a scheduled 4 x 12 tour, you are to report no later that 1700 hours on the first day of absence.

   b. If the absence occurs on scheduled 12 x 8 tour, you are to report by 0700 hours on the first day of absence.

ATTACHMENT A

c. The Health Management Division is located at

One Lefrak City Plaza – 15th Floor
59-17 Junction Boulevard
Rego Park, New York 11368

7. In the event that you are incapacitated which results in your inability to report to the Health Management Division on the first day of absence, you are to call the unit at (718) 595-2600, and notify the Medical Director or a designee, of your inability to report. In addition, you must submit a doctors note to the Medical Director from your personal physician or hospital, which confirms that your condition was severe enough to prevent your reporting to the Health Management Division on the first day of absence. The doctor's note shall state in non-medical terms, the following:

   a. Diagnosis;
   b. Treatment; and
   c. Prognosis is (including anticipated date of return to duty).

8. You may not leave your residence while on sick leave except in accordance with contractual agreement. In addition, the Department will carefully review and monitor your use of sick leave.

9. Failure to observe the responsibilities of a member classified as Chronic Absent will subject you to disciplinary charges.

10. Disciplinary Sanctions

   a. A member who reports sick on twelve (12) or more work days during a twelve (12) month period may be subject to disciplinary sanctions.

   b. Termination

      i. A member who reports sick forty (40) or more work days within a twelve (12) month period may be subject to termination.

      ii. A member who reports sick on fifteen (15) or more occasions within a twelve (12) month period may be subject to termination.

   c. Mitigation

   Before a disciplinary or termination action is commenced, the following mitigating factors shall be considered:

      i. The members use of sick leave since joining the Department;

      ii. Whether the sick leave is the result of a verified line-of-duty injury;

iii. Whether the use of sick leave procedures or follows pass days and holidays;

iv. Whether the use of sick leave is associated with ordered overtime; and

v. The nature of the illness.

____
Absence Control Monitor

____
Commanding Officer

____
Employee

Distribution:

1 copy to Employee
1 copy to Health Management Division
1 copy to Personal History Folder

THE CITY OF NEW YORK DEPARTMENT OF CORRECTION

ATTENDANCE COUNSELING

Instructions: To be completed by the supervisor conducting the counseling. Use attachments, if additional space is needed and indicate part and information section number on each additional page.

PRINT ALL INFORMATION

Facility:	Report Date:	Commanding Officer (or designee):

1 Person who you interviewed

Employee's Name:	Rank:	Shield/ID:

REASON FOR COUNSELING

A review of your Attendance Card for the past twelve (12) months, indicates that since ______________, you have been absent _______ times for a total of _______ days.

Your record puts you in proximity of meeting the requirements for designation as chronic absent.

This Counseling serves to advise you that additional use of Sick Leave may result in your being placed in a chronic absent classification and subject you to denial or revocation of one (1) or more discretionary benefits and/or privileges, as delineated in by Directive #2258R-A, ABSENCE CONTROL - UNIFORM SICK LEAVE PROGRAM.

REMARKS

____

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____

2

Date:	Time:	Place counseling was conducted:

Name:	Rank:	Shield#	Signature
Employee Interviewed			
Counseled By			

Original - Employee

Duplicate - Personal Folder

ATTACHMENT B

Form #2258-B

THE CITY OF NEW YORK DEPARTMENT OF CORRECTION

ATTENDANCE COUNSELING

Instructions: To be completed by the supervisor conducting the counseling. Use attachments, if additional space is needed and indicate part and information section number on each additional page.

PRINT ALL INFORMATION

Facility:	Report Date:	Commanding Officer (or designee):

1 Person who you interviewed

Employee's Name:	Rank:	Shield/ID:

REASON FOR COUNSELING

A review of your Attendance Card for the past twelve (12) months, indicates that since ______________, you have been absent _______ times for a total of _______ days.

Your record puts you in proximity of meeting the requirements for designation as chronic absent.

This Counseling serves to advise you that additional use of Sick Leave may result in your being placed in a chronic absent classification and subject you to denial or revocation of one (1) or more discretionary benefits and/or privileges, as delineated in by Directive #2258R-A, ABSENCE CONTROL - UNIFORM SICK LEAVE PROGRAM.

REMARKS

____

____

____

____

2

Date:	Time:	Place counseling was conducted:

Name:	Rank:	Shield#	Signature
Employee Interviewed			
Counseled By			

Original - Employee

Duplicate - Personal Folder

ATTACHMENT B

Form #2258-B

ATTACHMENT C

THE CITY OF NEW YORK DEPARTMENT OF CORRECTION

MEDICAL DOCUMENTATION

NOTE TO EMPLOYEE AND EXAMINING PHYSICIAN

This document is an official business record of the City of New York Department of Correction. Failure to fill out this form completely may result in denial of medical leave to the patient for the period covered by this medical note.

To be completed by physician:

Patient complains of:

Diagnosis (Please include positive findings)

Plan of treatment (Indicate all tests given and medication prescribed)

Prognosis

☐ Patient can return to full duty effective ______________________ (date)

☐ Patient can perform light duty* effective ______________________ (date)

☐ Patient should not return to work and is under my care. Return visit on ____________ (date)

* Light duty assignments range from limited inmate contact assignments to sedentary clerical assignments with no inmate contact requiring minimal physical activity. Please specify physical limitations.

Date of this exam	Time patient arrived for this exam ____a.m. ____p.m.	Time patient left after this exam ____a.m. ____p.m.	Office phone no.

Physician's name (please print)	Office address (street, city, zip)
Physician's license no. & BNdd no.	Physician's signature

This section to be completed by employee:

Name (last, first—please print)	Shield
Date of accident or illness	First day of treatment for this accident/illness
Social Security number	Command

I hereby acknowledge that the above information is true, and that all information contained herein has not been altered or changed. I am aware that, should this form contain any false information, I may be subject to disciplinary action.

Employee's signature ______________________ Date __________

For HMD use only:

Received by ______________________ Date __________

HM 1-87

ATTACHMENT C

THE CITY OF NEW YORK DEPARTMENT OF CORRECTION
MEDICAL DOCUMENTATION

NOTE TO EMPLOYEE AND EXAMINING PHYSICIAN

This document is an official business record of the City of New York Department of Correction. Failure to fill out this form completely may result in denial of medical leave to the patient for the period covered by this medical note.

To be completed by physician:

Patient complains of:

Diagnosis (Please include positive findings)

Plan of treatment (Indicate all tests given and medication prescribed)

Prognosis

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☐ Patient can perform light duty* effective ______ (date)

☐ Patient should not return to work and is under my care. Return visit on ______ (date)

* Light duty assignments range from limited inmate contact assignments to sedentary clerical assignments with no inmate contact requiring minimal physical activity. Please specify physical limitations.

Date of this exam	Time patient arrived for this exam ____a.m. ____p.m.	Time patient left after this exam ____a.m. ____p.m.	Office phone no.

Physician's name (please print)	Office address (street, city, zip)
Physician's license no. & BNdd no.	Physician's signature

This section to be completed by employee:

Name (last, first—please print)	Shield
Date of accident or illness	First day of treatment for this accident/illness
Social Security number	Command

I hereby acknowledge that the above information is true, and that all information contained herein has not been altered or changed. I am aware that, should this form contain any false information, I may be subject to disciplinary action.

Employee's signature ______ Date ______

For HMD use only:

Received by ______ Date ______

HM 1-87

FROM: CHIEF'S ORDER　　　　MSG#: 2001-001309
TO :　　　　SENT: 03/01/01　　1019 HRS
SUBJ:

TELETYPE ORDER NO. HQ -00823-0

DATE　MARCH 1, 2001

TO　COMMANDING OFFICERS, FACILITIES AND DIVISIONS

FROM　ROBERT N. DAVOREN, CHIEF OF DEPARTMENT

SUBJECT　OPERATIONS ORDER NO. 17/95 - (RESCISSION NOTICE)

1. OPERATIONS ORDER NO. 17/95, ENTITLED "MONTHLY REPORT OF CATEGORY A & B", DATED JUNE 19, 1995 IS HEREBY RESCINDED IN ITS ENTIRETY.

2. ALL MATTERS CONCERNING MONITORING MEMBERS DESIGNATED AS "CHRONIC SICK" ARE ADDRESSED IN DIRECTIVE NO. 2258R-A ENTITLED "ABSENCE CONTROL/UNIFORMED SICK LEAVE POLICY", DATED 2/14/00.

3. COMMANDING OFFICERS OF FACILITIES AND DIVISIONS ARE TO ENSURE THAT THE APPROPRIATE STAFF MEMBERS ARE APPRISED OF THE CONTENTS OF THIS TELETYPE ORDER AND THAT ALL RELATED COMMAND LEVEL ORDERS ARE REVIEWED AND AMENDED ACCORDINGLY.

AUTHORITY:
CHIEF OF DEPARTMENT
HA/CA

FROM: CHIEF'S ORDER   MSG#: 2009-000840
TO :   SENT: 02/02/09   1212 HRS
SUBJ:

TELETYPE ORDER NO.   HQ -00265-0

DATE   FEBRUARY 02, 2009

TO   COMMANDING OFFICERS, FACILITIES AND DIVISIONS

FROM   CAROLYN THOMAS, CHIEF OF DEPARTMENT

SUBJECT   **TREATING PHYSICIAN'S SUMMARY REPORT, FORM #HMD-3**

******* I M M E D I A T E   A T T E N T I O N *******

1. PENDING THE REVISION OF DIRECTIVE #2262R, ENTITLED "SICK LEAVE REGULATIONS FOR MEMBERS OF THE UNIFORMED FORCE," DATED 02/14/00 AND DIRECTIVE #2258R-A ENTITLED "ABSENCE CONTROL/UNIFORMED SICK LEAVE POLICY," DATED 02/14/00 THE FOLLOWING IS HEREBY AMENDED:

REMOVE ATTACHMENT "C" ENTITLED "MEDICAL DOCUMENTATION" (FORM HM1-87) DATED 8/24/87 FROM BOTH DIRECTIVES AND REPLACE WITH THE NEW **GREEN** FORM ENTITLED **"TREATING PHYSICIAN'S SUMMARY REPORT," FORM #HMD-3,** DATED 2/1/09.

NOTE: THE FOLLOWING INFORMATION HAS BEEN ADDED TO BETTER CAPTURE SPECIFIC INFORMATION FROM THE TREATING PHYSICIAN:

"PATIENT'S CURRENT COMPLAINT";
"SPECIFIC PROGNOSIS AS OF THIS DATE"; AND
"EXPECTED DURATION OF LIMITATIONS".

NEW MATERIAL BOLD AND UNDERLINED

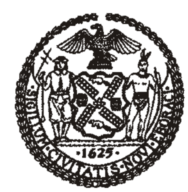
2. ALL OTHER PROVISIONS OF DIRECTIVES #2262R AND #2258R-A REMAIN IN EFFECT.

3. COMMANDING OFFICERS SHALL ENSURE THAT ALL RELATED COMMAND LEVEL ORDERS ARE REVIEWED AND REVISED ACCORDINGLY.

4. COMMANDING OFFICERS OF FACILITIES ARE DIRECTED TO ENSURE THAT THE APPROPRIATE PERSONNEL ARE APPRISED OF THE CONTENTS OF THIS TELETYPE ORDER AND INSTRUCTED ACCORDINGLY. COMMANDING OFFICERS ARE ALSO TO ENSURE THAT THIS TELETYPE ORDER IS POSTED IN APPROPRIATE EMPLOYEE AREAS.

5. THE COMMANDING OFFICER OF THE CORRECTION ACADEMY SHALL ENSURE THAT ALL RELEVANT LESSON PLANS ARE UPDATED TO CONFORM TO THE CONTENTS OF THIS TELETYPE ORDER.

AUTHORITY:
CHIEF OF DEPARTMENT
HA/CR



THE CITY OF NEW YORK
DEPARTMENT OF CORRECTION

HEALTH MANAGEMENT DIVISION	1 LEFRAK CITY PLAZA REGO PARK, N.Y. 11368 718-595-2500	Form # HMD-3 Eff. Date: 2/1/09

TREATING PHYSICIAN'S SUMMARY REPORT

Dear Doctor,

Kindly allow your patient to hand carry the following information to us. It is essential for us to evaluate his/her fitness for duty. This form ***must*** be returned to the evaluating physician at **Health Management Division** upon the patient's next appointment.

MUST BE FULLY COMPLETED BY TREATING PHYSICIAN:

Patient's current complaint: ____________________

____

____

Diagnosis (Please include positive findings) : ____________________

____

____

Prescribed treatment (Indicate all test(s) given and medication(s) prescribed) : ____________________

____

____

Specific prognosis as of this date: ____________________

____

Please specify limitations: ____________________

____

Expected duration of limitations

Date of this exam :	Time patient arrived for this exam: ________ (circle one) **A.M. P.M.**	Time patient left after this exam: ________ (circle one) **A.M. P.M.**	Office phone no.

Physician's Name : (please print)	Physician's license no. & DEA no. :
Office address : (street, city, zip code)	Physician's Signature :

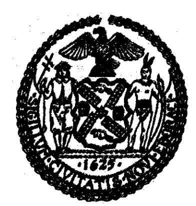
THIS SECTION MUST BE COMPLETED BY EMPLOYEE: (FORM WILL NOT BE ACCEPTED UNLESS FULLY COMPLETED, SIGNED AND DATED)

Name : (last name, first name) (please print)	Shield No. :	SS # :

Date of accident or illness:	First day of treatment for this accident/illness:	Command:

MEDICAL INFORMATION RELEASE: I hereby authorize the release of the above requested information by affixing my signature.

Employee Signature : ____________________ Date : __________



THE CITY OF NEW YORK
DEPARTMENT OF CORRECTION

DIRECTIVE

[ ] NEW [ ] INTERIM [X] REVISED			SUBJECT		
EFFECTIVE DATE **02/27/09**		*TERMINATION DATE	**ABSENCE CONTROL/UNIFORMED SICK LEAVE POLICY**		
CLASSIFICATION # **2258R-A**	SUPERSEDES **see below**	DATED **02/14/00**	APPROVED FOR WEB POSTING [X] **YES** [ ] **NO**	DISTRIBUTION **A**	PAGE **1** OF **1** PAGES
RECOMMENDED FOR APPROVAL BY REVIEW BOARD MEMBER			AUTHORIZED BY THE COMMISSIONER		
CAROLYN THOMAS, CHIEF OF DEPARTMENT SIGNATURE			MARTIN F. HORN SIGNATURE		

REVISION NOTICE

A. Directive #2258R-A entitled, ABSENCE CONTROL/UNIFORMED SICK LEAVE POLICY, dated 02/14/00 is hereby amended as follows:

Remove Attachment C (Form #HM 1-87) and replace with new Attachment C (Form #HMD-3), dated 02/01/09.

B. All other provisions of Directive #2258R-A remain in full force and effect.

ATTACHMENT - C

THE CITY OF NEW YORK
DEPARTMENT OF CORRECTION

HEALTH MANAGEMENT DIVISION	1 LEFRAK CITY PLAZA REGO PARK, N.Y. 11368 718-595-2500	Form # HMD-3 Eff. Date: 2/1/09

TREATING PHYSICIAN'S SUMMARY REPORT

Dear Doctor,

Kindly allow your patient to hand carry the following information to us. It is essential for us to evaluate his/her fitness for duty. This form ***must*** be returned to the evaluating physician at **Health Management Division** upon the patient's next appointment.

MUST BE FULLY COMPLETED BY TREATING PHYSICIAN:

Patient's current complaint: ______________________________

____

____

Diagnosis (Please include positive findings) : ______________________________

____

____

Prescribed treatment (Indicate all test(s) given and medication(s) prescribed) : ______________________________

____

____

Specific prognosis as of this date: ______________________________

____

Please specify limitations: ______________________________

____

Expected duration of limitations

Date of this exam :	Time patient arrived for this exam: ________ (circle one) **A.M.** **P.M.**	Time patient left after this exam: ________ (circle one) **A.M.** **P.M.**	Office phone no.

Physician's Name : (please print)	Physician's license no. & DEA no. :
Office address : (street, city, zip code)	Physician's Signature :

THIS SECTION MUST BE COMPLETED BY EMPLOYEE: (FORM WILL NOT BE ACCEPTED UNLESS FULLY COMPLETED, SIGNED AND DATED)

Name : (last name, first name) (please print)	Shield No. :	SS # :

Date of accident or illness:	First day of treatment for this accident/illness:	Command:

MEDICAL INFORMATION RELEASE: I hereby authorize the release of the above requested information by affixing my signature.

Employee Signature : ______________________________ Date : ____________