BROWARD HEALTH

Request for Sick Pay for One Day Procedure

Note: This form should ONLY be used for one day procedures.

Section 1: To be completed by Human Resources

HR Representative	HR Telephone No.	Today's Date

Section II: To be completed by the employee

Employee Name	Employee ID Number	Telephone Number

Please ***sign below*** regarding your one-day procedure and your request for Broward Health's Sick Pay Benefit.

Use of Sick Pay may be used for a one-day procedure if one of the following conditions are met:

- *In-patient hospitalization,*
- *Medically necessary out-patient procedure,*
- *Major dental surgery involving complex procedures requiring general anesthesia.*

*Note: Outpatient non-medically necessary cosmetic procedures **may not** qualify for Sick Pay benefits*

NOTE: Broward Health employees are eligible for a maximum pay for one day equal to the employee's normal work schedule in accordance with our Sick Pay Policy.

Employee Signature	Date

Section III: To be completed by the healthcare provider

INSTRUCTIONS: Your patient has advised that they will need to be absent from work due to a medically necessary/medical outpatient/inpatient procedure and is requesting that their absence be compensated under the Broward Health Sick Pay Benefit.

Please provide the following information for our review so that we can determine if your patient's absence qualifies or will qualify under our Sick Pay Benefit. Please provide your full contact information as requested below upon completion of the form.

1. Procedure being performed**:** _____

2. Date of procedure: _____ **(Please do not include or provide any additional time that may be needed for prep, testing or recovery)**

3. Will this procedure require any sedation or anesthesia: **Yes** _____ **No** _____

4. Facility where procedure is scheduled to be performed: _____

Provider's name {please print}_____**Type of practice/Medical Specialty:**_____

Business address: _____

Telephone: (___)_____ **Fax: (___)**_____

Signature of Health Care Provider_____ **Date:** _____

***** An office stamp may be used for the above contact information, in addition to a signature and date on the above lines.

PLEASE USE THE SPACE BELOW TO PROVIDE ANY ADDITIONAL MEDICAL FACTS THAT MAY BE NEEDED FOR OUR REVIEW AND FINAL APPROVAL.

_____

_____