

**The City School District of New York**  
 Division of Human Resources-Medical Bureau  
 65 Court Street, Brooklyn, New York 11201

**Confidential Medical Report and Medical Evaluation**

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

**1. To be completed by applicant or school secretary. Please type or print.**

Ms. _____ Mrs. _____	File No. _____	Social Sec. No. _____
Mr. Last Name _____	First Name _____	MI _____
		Regularly appointed _____ Regular Substitute _____ Per Diem Substitute _____
Home Address _____		License _____
Home Phone (____) _____	Zip _____	Date of Birth: ____/____/____
School _____	Borough _____	District _____
<b>Please check the purpose (A-E) in connection with which this form is being submitted and supply all information requested.</b>		
___ <b>A</b> Excuse of absence of more than twenty days for personal illness (sick leave) Initial Date of Current Absence ____/____/____ <b>Application form OP198 must be submitted through principal.</b>		
___ <b>B</b> Excuse of absence for alleged accident in line of duty From ____/____/____ to ____/____/____ <b>Application form OP198, report of injury to member of professional staff, and assignment form OP200 must be submitted through principal.</b>		
___ <b>C</b> Sabbatical Leave of Absence for Restoration of Health From ____/____/____ to ____/____/____ <b>Application form OP8 must be submitted through principal. List below all prior sabbaticals and leaves of absence without pay with dates and purpose of each.</b>		
___ <b>D</b> Leave of Absence without pay for Restoration of Health From ____/____/____ to ____/____/____ <b>Application form OP160 must be submitted through principal. List below all prior leaves of absence without pay and sabbaticals with dates and purpose of each.</b>		
___ <b>E</b> 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 Bureau.**

<b>Confidential and Strictly Privileged Medical Report</b>	
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): _____	
<b>In Surgical case:</b>	Nature of Operation _____ Date of Operation: ____/____/____
Date: _____	Signature of Attending Physician: _____, M.D.
Printed/Typed Name of Physician: _____	Phone: (____) _____
Address _____	Zip _____