COPY

SAN JOAQUIN COUNTY MOSQUITO AND VECTOR CONTROL DISTRICT
TIME OFF RECORD SHEET

DATE: 7-25-11 NAME: Tiffany Anderson Emp. # 306

It is requested that time off on 7-19, 20, 21, 22-11

consisting of 4 day(s) ___ hour (s) working time, be approved.

This time off be charged to:

Vacation ________

Sick Leave X 8H 16.0 hrs

Sick Leave due to family illness ________

I used or wish to use _____ days or _____ hours of accrued and available sick leave to care for an ill family member. The sick leave was or will be used on

__________________.

The family member is my __________________.

Compensation for overtime X 8H 16.0 hrs

Time off without pay ________

Workers' comp. time off ________

Jury Duty ________

Bereavement Leave 1 ________

Bereavement Leave 2 ________

(Emps': aunt, uncle, niece nephew, charged to sick leave)

For Office use only

_____ Vac

_____ Sick

_____ F.Sick

_____ Comp.Off

_____ W/C Off

[signature]

Employees' Signature

Date: 7-25-11

[signature]

Immediate Supervisor's Signature

KAISER PERMANENTE
MEDE 7373 West Lane Stockton CA 95210-3377 Main: 476-2000X0000

Kaiser Permanente Visit Verification Form

Patient Name: Tiffany K Anderson

Date Of Visit/Advice: 7/20/11
Date of Illness:

Tiffany K Anderson was seen in this office

Tiffany K Anderson **can return to full duties with no restrictions on** 7/22/2011

Tiffany K Anderson has been ill and unable to attend work from 7/19/2011 through 7/21/2011

Generated by CHARANJIT S. MANN MD on 7/20/11
Authorized by CHARANJIT S. MANN MD

http://kaiserpermanente.org

TELEPHONE TREATMENT/ADVICE VERIFICATION

>> VOT forms are ONLY available FOR PICK-UP during regular business hours (Mon-Fri)

***AACC RN SECTION**: Advice nurse must complete all questions in this RN section and *sign below.*

MRN: #07897964 **Member Name:** Anderson, Tiffany

Date July 22, 2011 **PCP/NP/Unempaneled:** Dr. Jasti

Department: Medicine **Facility:** Stockton

Member wants to pick up at alternate location: Dept: — **Facility:** —

THE ABOVE NAMED PERSON:

- Has been given telephone advice on: Date: July 22 -11 Time: 8:10 AM
- States that he/she has been ill and unable to attend work/school

from 07/22/11 through 07/22/11 (Not to exceed 3 days)

RN COMPLETE ONLY if member requests that the Chief Complaint is needed on the VOT. Nurse may complete with member's permission if employer requires reason for absence. Please list chief complaint using member's words and not name of protocol used (e.g.," stomach pains" instead of abdominal pain protocol). Member must go to facility to sign form.

- Gave Advice Related to Chief Complaint of: * HIPPA *
  (RN Complete on member request only, requires member signature prior to distribution)

***RN SIGNATURE & TITLE:** Patricia Eichele-Litts RN DATE: 07/22/11

***RN NAME (PRINTED)** Patricia Eichele-Litts RN LOCATION: Sacramento

***MEMBER SECTION**: To be signed by member if Chief Complaint filled out in RN Section above or TST Section below.*

I hereby authorize the Kaiser Permanente Medical Care Program to verify to my employer/school, upon request, the information contained in this form.

SIGNATURE (of Member or Responsible Person): ____________________

RELATIONSHIP TO MEMBER: ____________________ DATE: __________

***AACC CLERK SECTION**: Clerk to complete all information in this Clerk Section.*

Station: F **Fax #:** ____________________

***FACILITY SECTION**:*

1. If there is no chief complaint listed in RN Section, please keep in "will call" and give faxed form to member upon arrival.
2. If Chief Complaint not listed in RN Section, but Member requests; TST to list here:
   ____
3. If Chief Complaint listed in RN Section or TST Section, please have member sign in Member Section above and provide Member with copy.