American Airlines

Sick Verification Form

The completed Sick Verification Form must be provided to the Company verifying the absence referenced below is required by the employee's illness or injury.

A. This Section to be completed by the employee.

Name: _____ Employee Number: _____ Base: _____

Address: _____ Phone Number: _____

Absence Begin Date: _____ Actual or Expected Return to Work Date: _____

Name of Health Care Provider (HCP) for your illness or injury: _____

I grant permission for the Company to contact my HCP indicated above for clarification: Yes _____ No _____

_____ _____

Employee Signature Date

B. This Section to be completed by the HCP(s) indicated above. Only provide information for the illness or injury that gave rise to the above-referenced absence.

We would like to thank you for your care and treatment of our colleague and we ask that you partner with us by completing the information below. **Please type or print answers.**

1) **Date injury/illness began for purposes of this absence:** _____

2) **Is the employee able to work at this time? Yes _____ No _____**

If no, what is the anticipated date for return to work? _____

3) **Re-evaluation date?** _____

Health Care Provider (print name): _____

Specialty/Type of Practice: _____

Phone Number: _____ Fax: _____

Health Care Provider Signature: _____ Date: _____

Ground employees - fax completed Sick Verification Form to 817-931-7540
Flight Attendants – fax completed Sick Verification Form to 817-967-1382
Pilots – fax completed Sick Verification Form to 817-963-1189

Revised 4/15/2015