Torres Rojas, Genara FOIA 14417

From:
Sent: Saturday, November 16, 2013 8:42 PM
To: Duffy, Daniel
Cc: Torres Rojas, Genara; Van Duyne, Sheree; Qureshi, Ann
Subject: Freedom of Information Online Request Form

Information:

First Name: Jeffrey
Last Name: Caubet
Company: PATH
Mailing Address 1:
Mailing Address 2:
City:
State:
Zip Code:
Email Address:
Phone:
Required copies of the records: Yes

List of specific record(s):
I would like to request a copy of the instructions for completing form PA-3109 Extended SickHospitalizationInjury on Duty Report.

THE PORT AUTHORITY OF NY & NJ

FOI Administrator

November 25, 2013

Mr. Jeffrey Caubet

Re: Freedom of Information Reference No. 14417

Dear Mr. Caubet:

This is in response to your November 16, 2013 request, which has been processed under the Port Authority's Freedom of Information Code (the "Code", copy enclosed) for a copy of the instructions for completing Form PA-3109 Extended Sick Hospitalization Injury on Duty Report.

Material responsive to your request and available under the Code can be found on the Port Authority's website at http://www.panynj.gov/corporate-information/foi/14417-O.pdf.

Please refer to the above FOI reference number in any future correspondence relating to your request.

Very truly yours,

Daniel D. Duffy
FOI Administrator

Enclosure

2[illegible] Avenue [illegible] 17th Floor
[illegible]
T[illegible]
F: 21[illegible]

THE PORT AUTHORITY OF NY & NJ

INSTRUCTIONS: The supervisor completes Part A and forwards original to assigned Medical Clinic for all specified absences. Forwards one copy to Workers' Compensation Unit for all injury on duty absences. Retains last copy of form for reference.

PART A (TO BE PREPARED BY SUPERVISOR IMMEDIATELY UPON NOTICE OF EMPLOYEE'S ABSENCE)

EMPLOYEE'S NAME	EMPLOYEE NO.	JOB TITLE	
HOME ADDRESS		HOME OR OTHER TELEPHONE NUMBER WHERE EMPLOYEE CAN BE CONTACTED DURING ABSENCE:	
SUPERVISOR'S NAME	TEL. EXT.	FACILITY LOCATION	P.A. ZIP CODE

TYPE OF ABSENCE: (CHECK ONE)

- ☐ EXTENDED SICK – MORE THAN FIVE (5) WORKING DAYS (SEND COPY TO MEDICAL ONLY)
- ☐ HOSPITALIZATION – REGARDLESS OF LENGTH OF STAY (SEND COPY TO MEDICAL ONLY)
- ☐ INJURY/ILLNESS ON DUTY – FOR ANY TIME LOST FROM WORK (SEND COPIES TO MEDICAL AND WORKERS' COMPENSATION UNIT)

DATE ABSENCE BEGAN: _____/_____/_____ DATE OF HOSPITALIZATION: : _____/_____/_____ ANTICIPATED DATE OF RETURN (IF KNOWN): : _____/_____/_____

NAME OF TREATING PHYSICIAN (IF KNOWN)	ADDRESS	TELEPHONE NUMBER
NAME OF HOSPITAL (IF KNOWN)	ADDRESS	TELEPHONE NUMBER

DATE FORM PREPARED _____

PART B HEALTH STATUS MONITORING (FOR MEDICAL STAFF USE ONLY)

DATE FORM RECEIVED BY MEDICAL CLINIC _____ / _____ / _____	
DATE EMPLOYEE WAS CONTACTED _____ / _____ / _____	DATE TREATING PHYSICIAN WAS CONTACTED _____ / _____ / _____
CONTACT MADE BY _____	TITLE: _____