NIPSCO

Exhibit 2
Sick Leave Claim Form

NORTHERN INDIANA PUBLIC SERVICE COMPANY
SICK LEAVE CLAIM FORM

TO BE COMPLETED BY EMPLOYEE (Incomplete forms will be returned to the employee and no benefits will be paid until a completed form is received

Name:	Home Phone:	Hire Date: Employee ID Number:
Job Classification:	Work Phone:	Location/Dept:

Last Day Worked:	First Day of Sick Leave:	Returned to Work on:
Illness O Injury O	Is Illness/injury a result of your occupation? No O Yes O	

NATURE OF ILLNESS/INJURY (if injury, describe when, where and how it occurred)

I affirm that the information contained on this form is true and correct.

Employee's Signature: _____ Date: _____

TO BE COMPLETED BY PHYSICIAN (Incomplete forms will be returned to the employee and no benefits will be paid until a completed form is received} IS THIS EMPLOYEE UNABLE TO WORK DUE TO THIS ILLNESS OR INJURY: No O Yes O

DIAGNOSIS OR NATURE OF ILLNESS/INJURY:

DATE ILLNESS/INJURY BEGAN:	DATE(S) EXAMINED FOR THIS CLAIM:

In your medical opinion, did the illness/injury or symptoms diagnosed from this examination prevent the employee from working beginning with the first day of sick leave, shown in the box above, prior to this examination? No I:I Yes I:I Comments:

Was Hospitalization Required? No O Yes O	Was Medication Prescribed? No O Yes O
If yes, Admittance date: _____	Was surgery required: No O Yes O
Discharge date:	If yes, date of surgery:

O THE EMPLOYEE IS NOT RELEASED TO RETURN TO WORK. ESTIMATED DATE OF RETURN:

O THE EMPLOYEE IS RELEASED TO RETURN TO WORK. RETURN TO WORK DATE:

LIST LIMITATIONS, if any *(No Diagnostic Information):*

Expected Duration of Limitations:

If Re-exam is necessary, on what date?

As a result of your authorization of absence from work, employer may incur a liability for Sick Leave Benefits. This form may only be signed by a Licensed Physician, Licensed Nurse Practitioner, Physician Assistant, or Oral Surgeon.

Signature: _____ Speciality/Practice: Print Name: _____

Date Signed: Phone: