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|  |  |  | FICHE DE SAISINE DU CONSEIL MEDICAL – FORMATION RESTREINTE |  |  |  |
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|  | **IMPORTANT** : Afin de permettre l’instruction de la demande, **l’ensemble des champs doivent obligatoirement être renseignés** et les **pièces demandées jointes au dossier**. En cas d’incomplétude de la saisine, celle-ci vous sera retournée pour compléments. Dans l’attente, l’instruction ne pourra débuter. |  |  |
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|  | **Renseignements concernant l’agent** |  |
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|  | Madame |  |  | Monsieur |  |  |  |  |  | Adresse : |  |  |
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|  | Nom d’usage : |  |  |  | Complément : |  |  |
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|  | Prénom(s) : |  |  |  | Code postal : |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | Date de naissance : |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Ville : |  |  |
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|  | Statut applicable : |  | Titulaire |  | Contractuel |  | Stagiaire |  | Ouvrier d’état |  |  |  |  |  |  |
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|  | Fonction publique : |  | Etat |  | Territoriale |  | Hospitalière |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | Corps : |  |  |  | Grade : |  |  |
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|  | Entrée dans l’Adm. : |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Titularisation : |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | Fonction : |  |  |  | Téléphone : |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  Courriel :  |  |   |  |  |  |  |  |
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|  | Durée de travail : |  | Temps plein |  |  |  | Temps partiel |  | % |  |  |  | Temps non complet |  | Heures |  |
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|  | **Renseignements concernant le service en charge du dossier** |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Entité juridique\* : |  |  |  | Service RH\*\*\* : |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Structure\*\* : |  |  |  | Nom du référent : |  |  |
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|  | Adresse : |  |  |  | Téléphone |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | Complément : |  |  |  | Courriel : |  |  |
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|  | Code postal : |  |  |  |  |  |  |  |  |  |  |  |  |  |  | \*Entité juridique de rattachement : Agriculture, Culture, Défense, Economie, Santé, Travail, Justice, etc.\*\*Structure d’affectation : Agence de santé, Centre hospitalier, etc.\*\*\*Service RH : en charge de la gestion du dossier médical de l’agent |  |
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|  | **Renseignements concernant la demande** |  |
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|  | *Circonstances conduisant à la saisine du conseil* |  |
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|  |  | OCTROI (O) |  |  |  | RENOUVELLEMENT (R) |  |  |  | MISE EN CONGÉS D’OFFICE (M) |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | *Type de congé demandé (O) (R) (M) = combinaisons possibles* |  |  | **À compter du\*** : |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  |  |  | CMO : Congé ordinaire de maladie (O) |  |  |  |  | Reclassement dans un autre emploi (M) |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | CLM : Congé de longue maladie (O) (R) (M) |  |  |  |  | Aptitude/inaptitude aux fonctions (M) |  |
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|  |  |  | CLM : Congé de longue maladie fractionné (O) (R) (M) |  |  |  |  | Reprise à temps complet (O) |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | CLD : Congé de longue durée (O) (R) (M) |  |  |  |  | Temps partiel thérapeutique (O) (R)\*  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | \*si avis discordant |  |  |  |  |  |  |  |
|  |  |  | CGM : Congé de grave maladie (O) (R) |  |  |  |  | Congés pour cure thermale (O) |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | Disponibilité pour raison de santé (O) (R) (M) |  |  |  |  | CMS : Recours au Comité Médical Supérieur |  |
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|  |  |  | Congés sans traitement (O) (R) (M)  |  |  |  |  | Autre : |  |  |
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|  |  |  | Majoration pour assistance d’une tierce personne (O) (R) \* |  |  |
|  |  |  | \*si avis discordant |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | \*Correspondant à la date de début d’arrêt en continu (rétroaction si l’agent est en CMO)  |  |

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|  | Compléments ou précisions éventuelles sur la demande : |  |
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|  | **Renseignements concernant le médecin du travail** |  |
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|  | Nom du médecin : |  |  |  | Téléphone |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | Courriel :  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | Pièces à joindre obligatoirement : * Lettre de l’intéressé-e précisant la nature du congé demandé ;
* Certificat médical détaillé du médecin traitant **sous pli confidentiel ;**
* Certificat médical administratif ;

 Des **pièces spécifiques au droit demandé** peuvent être exigées. |  |
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|  | **Relevé des congés pour raison de santé déjà obtenus après avis du conseil médical** |  |
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|  | Congés ordinaires de maladie au-delà de 6 mois | du : |  |  |  |  |  |  |  |  |  | au : |  |  |  |  |  |  |  |  |  | durée : |  |  |
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|  | Congés de longue maladie | du : |  |  |  |  |  |  |  |  |  | au : |  |  |  |  |  |  |  |  |  | durée : |  |  |
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|  | Congés de longue durée | du : |  |  |  |  |  |  |  |  |  | au : |  |  |  |  |  |  |  |  |  | durée : |  |  |
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|  | Congés grave de maladie | du : |  |  |  |  |  |  |  |  |  | au : |  |  |  |  |  |  |  |  |  | durée : |  |  |
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|  | Temps partiels pour raison thérapeutique | du : |  |  |  |  |  |  |  |  |  | au : |  |  |  |  |  |  |  |  |  | durée : |  |  |
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|  | Disponibilité d’office pour raison santé / Congés sans traitement | du : |  |  |  |  |  |  |  |  |  | au : |  |  |  |  |  |  |  |  |  | durée : |  |  |
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|  | Fait à : |  |  |  |  |  |
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