

SICK LEAVE BANK
PHYSICIAN'S STATEMENT

TO BE COMPLETED BY PATIENT AND RETURNED

PATIENT'S NAME _____

ADDRESS _____

SCHOOL/DEPARTMENT _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned physician to release any information required in the course of my examination or treatment. It is further authorized that the information contained herein may be forwarded to the physician(s) designated by the Sick Leave Bank Committee, if required.

TO BE COMPLETED BY PHYSICIAN

Dear Doctor:

Kindly provide sufficient medical information to allow the Sick Leave Bank Committee to render a fair and reasonable decision regarding the illness of your patient. You may use this form and submit a narrative or photocopies of your records with this form.

Thank you!

Brief description of illness (Layman's language, please.)

If still disabled, date patient should be able to return to his/her regular duties, _____

Patient was under my care and unable to work:

FROM _____ THROUGH _____

Physician's Name (Print)

Telephone

Date

Street Address

City or Town

State

ZIP Code

This is to certify that the above patient has been examined by me on _____.
In my opinion, by reason of the above described condition, the patient (is) (is not) presently physically or mentally incapacitated for the performance of duty.

Physician's Signature

PLEASE RETURN TO PATIENT FOR SUBMISSION WITH BANK REQUEST FORM