NEW DIANA INDEPENDENT SCHOOL DISTRICT
PHYSICIAN'S STATEMENT
Sick Leave Bank

TO BE COMPLETED BY EMPLOYEE/PATIENT AND RETURNED

Patient's Name_____ Physician_____

Address _____ Address_____

_____ _____

Campus/Dept: _____ Phone _____

Authorization to release information: I hereby authorize the undersigned physician to release any information to allow the Sick Leave Bank Board of Directors 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.

_____ _____

Signature of Applicant Date

TO BE COMPLETED BY PHYSICIAN

Please provide sufficient medical information to allow the Sick Leave Bank Board of Directors 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

_____

_____

_____

Condition **was / was not** pre-existing

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

Patient was under my care and unable to return to work from :_____ to _____ _____.

_____ _____

Physician's Signature Date

PLEASE RETURN TO PATIENT FOR SUBMISSION WITH SICK LEAVE BANK REQUEST FORM