CHATHAM CENTRAL SCHOOL DISTRICT
50 Woodbridge Avenue, Chatham, NY 12037

Sick Leave Bank Physician's Statement Form

Employee Information (to be completed by Patient/Employee)

Name:_____
First Middle Last

Address:_____
Street City State Zip

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Authorization to Release Information

I hereby authorize the undersigned physician to release any information to the Sick Leave Bank Committee during the course of my examination or treatment. I acknowledge that the Sick Bank Committee may contact my physician in the event that clarification is needed.

_____
Employee Signature Date

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Physician's Statement
(to be completed by the treating physician)

The medical diagnosis of the condition(s) is : (state date of surgery if applicable)

_____

_____

_____

Please check those that apply and sign below:

____ I certify that the patient is being treated by me or a member of my practice for the above diagnosis.

____I certify that the above diagnosis renders the patient unable to perform his/her occupation during the period specified.

____ I certify that the treatment for the above diagnosis and/or the effects of such treatment requires absence from work for at least 10 days (may be contiguous or intermittent.)

____ I certify that treatment(s) and/or procedure(s) are medically necessary and non-elective.

____ I certify that treatment(s) and/or procedure(s) may not medically be deferred until a school recess period.

Anticipated dates of absence: _____ Intermittent _____Contiguous ____

_____
Physician's Name (Print) Date Physician's Signature

Physician's Address:_____
Street City State Zip

Physician's Telephone Number:_____