COFFEE COUNTY BOARD OF EDUCATION

SICK LEAVE BANK PHYSICIAN'S STATEMENT

TO BE COMPLETED BY PATIENT

NAME _____
LAST FIRST MIDDLE

ADDRESS _____

SOCIAL SECURITY NO._____ HOME PHONE _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned physician to release any information required in the course of my examination or treatment to the Trustees of the Sick Leave Bank.

_____ _____
SIGNATURE DATE

TO BE COMPLETED BY PHYSICIAN

Brief description of illness (Layman's language please) _____

_____

_____

If still disabled, date patient should be able to return to work _____

Patient was under my care and unable to work:

From _____ through _____

Physician's Name (Print) _____

Office Phone Number _____

Address _____
STREET CITY/STATE ZIP

_____ _____
SIGNATURE DATE

PLEASE RETURN TO PATIENT FOR SUBMISSION WITH SICK LEAVE REQUEST FORM