CUMBERLAND COUNTY SCHOOLS
ENGAGE INNOVATE EMPOWER

Sick Leave Bank Physician's Statement

To be Completed by Patient:

Patient Name: _____ SSN: _____

Release Statement: 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.

_____ _____
Patient Signature Date

Physician's Name: _____ Phone: _____

Office Address: _____

To Be Completed by Physician:

From_____ through _____, the above named patient was/is under my care and unable to perform his/her work.

- Briefly describe illness/condition (please use lay terms when possible and print legibly):

_____

_____

_____

_____

- If currently disabled, when will the patient be able to return to work:_____

_____ _____
Physician's Signature Date

(rev 5/11/2021)