OAK RIDGE SCHOOLS

CERTIFIED SICK LEAVE BANK

PHYSICIAN'S STATEMENT

NAME (as listed on Social Security Card)

_____

Last First Middle

Last 4 Digits of SSN: _____

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.

_____ _____

Date Applicant's Signature

_____

TO BE COMPLETED BY PHYSICIAN:

Please provide a brief description of the illness: _____

_____

_____

Is this absence due to elective (see policy) surgery? _____Yes _____No

Patient is under my care from _____ _____

Month/Day/Year Month/Day/Year

Date of initial diagnosis of this illness/injury: _____

Dates patient unable to work due to this illness/injury: _____

Date patient will be able to assume full duties: _____

Physician's Name (Please Print): _____

Telephone Number: _____

Address: _____

Street City/State Zip

_____ _____

Physician's Signature Date

PLEASE RETURN TO OAK RIDGE SCHOOLS, ATTN: HUMAN RESOURCES (f) 865-425-9023