EUFAULA PUBLIC SCHOOLS

Sick Leave Bank - Physician's Statement

I hereby authorize my physician to release the information requested on this form, and to give additional information tomy employer should it be requested.

Name: [ ] Signature: ____

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Dear Physician:

The above named employee is requesting benefits under the provisions of the Eufaula School's Sick Leave Bank. The purpose of this program is to assist the employee who is incapacitated by a long term life threatening illness. Please provide as much information as possible:

☐ The above named employee is not able to continue his/her contractual responsibilities for the following incapacitating medical conditions:

[ ]

☐ The date in which the employee should be physically able to resume his/her contractual responsibilities.

Date: [ ]

****

Physician's Name: First, Middle, Last [ ]

Physician's Signature: ____ Date: ____________________

Office Address:

[ ]

Telephone Number: [ ]

Thank You For Your Time and Cooperation