EAST ALLEN EDUCATION ASSOCIATION
SICK LEAVE BANK MEDICAL FORM
CONFIDENTIAL

This form completed, dated, and signed, must accompany your application for Sick Leave Bank days.

STATEMENT OF APPLICANT

Name _____
Date of illness or injury (if injury, describe accident including date and place of injury)

Was this illness or injury work related? Yes No

I hereby authorize the designated physician to release any medical information necessary to consider this application. This authorization expires one year from the date signed.

Signature of Applicant _____
Date _____

PHYSICIAN'S STATEMENT

Date first consulted for this condition _____

Diagnosis of illness or injury _____

Please provide a clear, concise, and complete statement of the medical diagnosis confirming a catastrophic and incapacitating effect on the patient.

Lab tests performed and conclusion rendered:

Medication prescribed:

Treatment being pursued. (If surgery is recommended, is the procedure of an urgent nature?)

If this diagnosis is of a psychological nature only, please complete the following:

Plan for treatment: Counseling Inpatient Outpatient

Duration/frequency of treatment

PROGNOSIS FOR RETURN TO WORK

Is the patient capable of performing normal work related duties while under treatment for the present condition?

If not, give prognosis for return to work.

I certify that the above statements are accurate to the best of my professional knowledge.

Signature of Physician _____
Date _____