

Greene County Board of Education  
Sick Leave Bank Physician's Statement  
(Revised June 2012)

**TO BE COMPLETED BY PATIENT**

Name: \_\_\_\_\_  
(First) (Middle) (Last)

Address: \_\_\_\_\_  
(City) (State) (Zip)

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION:**

I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment.

\_\_\_\_\_  
(Signature of Employee)

\_\_\_\_\_  
(Date)

**TO BE COMPLETED BY PHYSICIAN**

Brief description of illness (Layman's language please) \_\_\_\_\_  
\_\_\_\_\_

If surgery is required, please complete the following:

- a. Surgery is an emergency and needs to be scheduled immediately.     Yes     No
- b. Surgery is elective and can be scheduled later.     Yes     No
- c. Surgery can wait until extended school break     Yes     No

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) \_\_\_\_\_ Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City/State) (Zip)

**PLEASE RETURN TO PATIENT FOR SUBMISSION WITH SICK LEAVE REQUEST FORM**

Original: To Greene County School file;    Copy: To Employee