Greene County Board of Education
Sick Leave Bank Physician's Statement

(Revised April 2019)

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: _____

Physician's 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