SAAAAC
SECRETARIES & ASSISTANTS ASSOCIATION of Anne Arundel County

CONFIDENTIAL SICK LEAVE BANK PHYSICIAN'S STATEMENT

Part 1 is to be completed by patient and submitted to the Physician for completion of PART #2 before mailing to SAAAAC Sick Leave Bank with the Sick Leave Bank Request Application Form.

PART 1: TO BE COMPLETED BY PATIENT

Name: _____
Last **First** **Middle** **Employee ID #**

Address: _____
Street (Number & Name) **City** **State** **Zip**

AUTHORIZATION TO RELEASE Information: I hereby authorize the designated physician to release to **SAAAAC Sick Bank Leave Committee (SLBC)** pertinent information from my medical file gathered during the course of my examination or treatment.

_____ _____
Signature of Patient Authorizing Release of Records: **Date**

_____ _____
Name of Physician **Area Code & Telephone Number**

_____
ADDRESS OF PHYSICIAN (Street, City, State, Zip Code)

PART 2: TO BE COMPLETED BY PHYSICIAN: Complete and concise statement of the medical diagnosis in layman's terms confirming the catastrophic and incapacitating nature of the condition of the patient.

Please complete the appropriate section below:

1 Patient was under my care and disabled. **DATE** **From _____To_____**	**2 Date Patient should be able to return to work.** **DATE _____**	**3 It appears unlikely that this patient will be able to return to this type of employment. Check box below.** ☐
Physicians Name (PLEASE PRINT)		**Office Telephone Number**
Physician's Signature		**Date**
PHYSICIAN STAMP OR ATTACH A BUSINESS CARD		