SICK LEAVE BANK
PHYSICIAN'S STATEMENT

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

NOTE: The Physician's portion **must** be **signed** and **stamped.** No exceptions.

Patient's Name and Address (Street, City, State, Zip Code

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 Zipcode)

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.	**2** Date patient should be able to return to work.	**3** It appears unlikely that this patient will be able to return to this type of employment. ☐
From _____ To _____	Date _____	

Physicians Name (Print)	Area Code +Number
Physician's Signature	Date

Physician Stamp

Revised 2/06/06