SICK LEAVE BANK PHYSICIAN'S STATEMENT

Patient's Name:_____

Patient's Address:_____

I authorize_____ to release all records, including but not limited to medical and/or psychological records, related to this claim to Kenosha Unified School District's Sick Leave Bank and the Office of Human Resources.
(Physician's name)

Employee Signature:_____ Date:_____

MEMO TO PHYSICIAN:
Compensation benefits from the Sick Leave Bank (SLB) are available to SLB members who have exhausted all accumulated leave and are experiencing a serious/catastrophic illness or injury. Please provide the Sick Leave Bank all of the information requested. An incomplete statement will delay processing. Thank you.

DIAGNOSIS AND NATURE OF ILLNESS:_____

_____

PROGNOSIS_____

Have you treated the patient previously for this condition? Yes_____ No_____

Please provide detailed information on TREATMENT PLAN:_____

_____

_____

PRESCRIBED MEDICATION:_____

_____

Beginning and estimated ending date for the period of incapacity:_____/_____
Beginning Ending

Is patient able to work now?_____ DATE PATIENT CAN RETURN TO WORK_____
A specific date is necessary, or the application will not be processed

Will patient require intermittent leave for follow-up care after the initial leave? Yes_____ No_____

Please explain why treatment cannot be postponed to a non-work period:_____

_____

_____

_____ _____
Physician's Signature Date

Please Circle one: Physician Psychiatrist Licensed Clinical Psychologist

- Return the original Application and Physician's Statement to the KUSD Office of Human Resources.
- The Physician can **fax it to KUSD Human Resources at 262-359-7777.**