



**EMPLOYEES' SICK LEAVE BANK
ATTENDING PHYSICIAN'S STATEMENT**

Patient's Name/Relationship to employee: _____

Employee's Name: _____ Social Security #: _____

Nature of injury, surgery or critical illness. **PLEASE BE VERY SPECIFIC:** _____

Date of initial onset of condition: _____

Dates of treatment: _____

Dates hospitalized, if any, and name and address of hospital:

Date admitted: _____	Date discharged: _____
Name of hospital: _____	
Address of hospital: _____	

What is the earliest date this patient was treated for this condition? _____

Is patient still under your care? Yes No

How long was / will patient be unable to work? _____

Date patient can return to work: _____

Date of follow-up examinations: _____

Signature of Physician: _____ Date: _____

Type or print Physician's name: _____

FORM MUST BE COMPLETE AND SPECIFIC TO BE CONSIDERED. INCOMPLETE INFORMATION WILL RESULT IN A DELAY IN CONSIDERATION.