MONTGOMERY COUNTY EDUCATION ASSOCIATION
12 TAFT COURT - ROCKVILLE, MD 20850
301/294-6232; Fax: 301/309-9563

SICK LEAVE BANK PHYSICIAN'S STATEMENT

Completion of this form is mandatory. No substitutes will be accepted.

TO BE COMPLETED BY PATIENT:

Patient's Name _____ Work Location _____

Home Address _____

_____

Authorization to Release Information: I hereby authorize the undersigned physician to release to the Sick Leave Bank Committee any information requested with respect to this claim.

Signature _____ Date: _____

Date of Birth _____

1. What was the first day of absence from work due to this illness, injury, or disability?
   Month _____ Day_____ Year_____

2. Have you ever had same or similar condition? [ ] Yes [ ] No If "yes", state when and briefly describe.

3. Is condition due to injury or sickness arising out of your employment? [ ] Yes [ ] No If "yes", describe.

TO BE COMPLETED BY PHYSICIAN

A. Physical Illness

1. Nature of Disability

2. Symptoms

3. Clinical findings (e.g., x-rays, lab data)

4. Treatment (e.g., surgery, medication)_____

   a. Period of hospitalization/Date of surgery_____

   b. Other confinement? Specify_____

5. Anticipated date of return to work. (**Must be completed**) _____

6. For **maternity related disabilities**, please complete the following:

   a. Date of delivery: _____

   b. Type of delivery: _____
   (verification of C-section birth must be provided after delivery)

   c. Specify complications: _____

B. Psychiatric Disability

1. Most recent appointment _____

2. Symptoms: _____

3. Has patient been hospitalized or received residential treatment for condition? [ ]Yes [ ]No

   If "yes" specify (including dates) _____

4. List patient's medications _____

5. Specify treatment plan. Nature of therapy? _____

   _____

6. Anticipated date of return to work. (**Must be completed**)_____

C. For all Disabilities

(***Must be completed or form may be returned without a decision from the Committee*****)**

What are patient's job related limitations?

a. temporary or permanent (please circle applicable term)
b. none, slight, moderate, severe (please circle applicable term)

This leave consists of days contributed by MCPS employees, and may be used for extended illness, injury, or disability only by the contributing member.

Physician's Name (Please print clearly) Signature Date Phone

_____

Street Address City State Zip Code

_____