MEDICAL FORM FOR SICK LEAVE BANK

Certification of Physician or Practitioner

1. Employee's Name: _____

2. Employee's Title: _____

3. Diagnosis (Illness or Injury): _____

4. Date condition commenced: _____

5. What are the employee's current restrictions?

6. Anticipated date employee will be able to return to work: _____

7. If you cannot determine when the employee can return, when will the employee be reevaluated? _____

8. Regimen of treatment to be prescribed. Indicate general nature and duration of treatment, including referral to other providers of health services. Include schedule of visits or treatment.

Signature of Physician or Practitioner: _____ Date: _____

Print Physician or Practitioner's Name: _____

Type of practice (Field of Specialization, if any): _____

Address of Physician or Practitioner: _____

Physician's Phone No.: _____ Physician's Fax No.: _____

Please fax responses to 901-448-2994.