SUFFOLK PUBLIC SCHOOLS

P.O. BOX 1549

SUFFOLK, VIRGINIA 23439

PHYSICIAN'S STATEMENT

SICK LEAVE BANK

I hereby authorize my physician to release the information requested on this form and to provide additional information upon request of my employer.

Signature _____Date_____

Dear Physician:

The above named employee is requesting benefits under the provision of the Suffolk Public Schools' Sick Leave Bank. This program is maintained and supported by the contributions of sick leave days by individual members with the purpose of assisting an employee of incapacitated by an illness or injury.

Please describe the nature of the illness or injury that will prevent the employee from fulfilling his/her contractual responsibilities.

_____

_____

_____

Treatment Prescribed:_____

Duration of Treatment:_____

Last Appointment Date:_____

I hereby certify that the above named employee of Suffolk Public Schools is totally unable to meet contractual responsibilities due to the conditions described above. The return work date is projected to be _____.

Physician's Signature:_____**Date:**_____

Address:_____

STAMPED SIGNATURES ARE NOT ACCEPTED!