CLASSIFIED PERSONNEL

SICK LEAVE BANK MEDICAL CERTIFICATE FORM

Sick Leave Bank days may be granted only for instances of disability illness, injury, or quarantine of the individual member of the member's immediate family as defined by policy 03.22321. Grants of sick leave from the Sick Leave Bank shall not be made to any member for the purpose of undergoing elective surgery or during any period the member is receiving disability benefits from Social Security of the County Employees Retirement Plan.

Name of Patient: _____
Name of Physician: _____
Physician's Specialty: _____
Office Address: _____
City: _____ State: ____ Zip: _____ Phone: _____

Date patient needs to be (or was) confined to hospital, other medical facility, or home:
Anticipated beginning: _____ Ending: _____

Type of illness or injury: _____

1) In your medical opinion, does this illness/injury prevent the employee from performing his/her regular duties? _____

2) In your medical opinion, are there any job duties the patient could perform?
_____

3) How long has this patient been under your care? _____

4) Do you see this patient on a regularly scheduled basis? _____

5) In your medical opinion, when is the patient expected to return to work? _____

6) Is there any other information you can share with the Sick Leave Bank committee that would assist us in making a determination for this request? _____
_____
_____

I hereby certify that it is/was medically necessary for the above patient to be confined to hospital, other medical facility, or home as stated above.

Physician's Signature _____ **Date** _____

Attach this form to the Sick Leave Bank Usage Application and return it to the Secretary in Instructional Services located at the Central Office

Revised: 3-23-04