Alachua County Public Schools

Division of Human Resources

Physician's Statement

(Please Print)

Patient's Name: _____

Address: _____

(city) _____ *(state)* _____ *(zip)* _____

Phone No: _____ Employee ID No: _____

Dear Doctor:

In order for the Sick Leave Bank Committee to determine if the above-named patient meets the criteria for the Sick Leave Bank, we are asking (with the patient's consent) for the following information:

Please describe the nature of the above-referenced patient's illness:

What kind of treatment will the patient receive?

Do you expect a normal recovery period? ☐Yes ☐No

How long do you expect the patient will need to be out from work? _____

If surgery is involved, is this emergency surgery or can it be scheduled? _____

Why?

_____

Physician's Name (Please Print)

_____ _____

Physician's Signature *Date*

Please feel free to add any additional information you feel is pertinent to this patient's illness.

Please return this form to:
Division of Human Resources (ATTN: Sick Leave Bank Committee)
620 East University Avenue
Gainesville, FL 32601