



Division of Human Resources  
**Compassionate Leave Program  
Physician's Statement Form**

Employee Name: \_\_\_\_\_ Employee ID: \_\_\_\_\_

I certify that I am the patient or  I certify that I am the patient's caregiver.

**This section to be completed by patient prior to submitting to Physician**

Patient's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature Authorizing Release of Medical Information

Dear Doctor:

In order for Alachua County Public Schools to determine if the above referenced patient or patient's caregiver meets the criteria for the Compassionate Leave Program, we are requesting (with the patients consent) the following information:

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What kind of treatment will the patient receive?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long do you expect the patient may need to be out of work?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please return this form to: Personnel Services Department  
(Attn: Compassionate Leave Program)  
620 East University Avenue, Gainesville, FL 32601**