



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