



Division of Human Resources
PHYSICIAN'S STATEMENT
(Please Print)

Patient's Name: _____

Address: _____

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? _____

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