

Cumberland County Board of Education & Cumberland County Education Association

**Sick-Leave Bank  
Physician's Statement**

\* Please attach this sheet to your request form and return them both to the Central Office.

**To be completed by patient:**

Patient's Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Release Statement: I hereby authorize the undersigned physician to release any information, required in the course of my examination or treatment, to the Trustees of the Sick-Leave Bank.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Physician's Name: \_\_\_\_\_ Office Phone: \_\_\_\_\_

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

**To be completed by physician:**

- From \_\_\_\_\_ through \_\_\_\_\_, this patient was/is under my care and unable to work.
- Briefly describe illness/condition (please use lay terms whenever possible):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- If currently disabled, when is the patient expected to return to work?
- \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date