**SICK LEAVE POOL ATTENDING PHYSICIAN’S STATEMENT**

**Employee Information\* (to be completed by employee):** Complete the Employee Information portion below. The attending physician must fully complete the remainder of the form. A request for the establishment of a sick leave pool will **not** be considered until the ***Attending Physician’s Statement*** is received. **PLEASE PRINT CLEARLY.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Employee’s Legal Last Name** | **Employee’s Legal First Name** | | **Employee’s EIN** |
| **Employee’s Campus/Department** |  | |  |
| **Patient’s Name** |  | **Patient’s Relationship to Employee** |  |

Employee’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Certification\* (to be completed by the attending physician):** Please complete the following information regarding the patient named above. **PLEASE PRINT CLEARLY.**

Describe illness or injury in lay terms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

The patient’s illness or injury (check all that apply): ❑ is life threatening, ❑ requires in-patient hospitalization, and/or ❑ is expected to result in disability or death.

Explain the short-term prognosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Explain the long-term prognosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates of treatment: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ through \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Is patient still under your care? ❑ Yes ❑ No

Hospitalization: Date admitted \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Date discharged \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Name and address of hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

|  |  |
| --- | --- |
| **Attending Physician’s Printed Name** | **Type of practice /medical specialty:** |
| **Business address:** |  |
| **Phone:** | **Email:** |

**I certify that the information given on this Attending Physician’s Statement is accurate and true.**

Physician’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee’s family members, 29 C.F.R. § 1635.3(b).