POLK STATE COLLEGE

SICK LEAVE POOL

ATTENDING PHYSICIAN'S STATEMENT

NAME OF PATIENT:_____

Last Four of SOCIAL SECURITY NUMBER: _____

Statement of Patient: In support of my application for sick leave hours from the PSC Sick Leave Pool, I authorize all health care professional, including, but not limited to, physicians, psychiatrists, chiropractors, or any other examining health care professional, to release information concerning my illness/injury and any other pertinent data to HR and Sick Leave Pool Committee.

_____ _____

Signature of Patient **Date**

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Physician's Statement

Please clearly print or type the requested information. Use additional sheets if necessary.

PHYSICIAN'S NAME_____ **License No.**_____

MAILING ADDRESS_____ **Phone No.** _____

Date you first examined patient for this condition:_____

1. Name of referring health professional: _____ Phone No._____
2. Diagnosis:_____
3. Current Condition:_____
4. Is the current condition Serious and/or Catastrophic? ___Yes ___No Please explain:_____
5. Course of Treatment:_____

   _____
6. Can patient currently perform essential functions of job? (Please see attached position description)

   _____
7. Prognosis_____
8. Anticipated date of return to work:_____

_____ _____

Physician Signature Date

Return form to:

Polk State College
Human Resources Office
999 Avenue H, NE
Winter Haven, FL 338811
Fax: (863) 297-1075

Rev03/10