SAN ANGELO INDEPENDENT SCHOOL DISTRICT
Catastrophic Sick Leave Bank

Certification of Health Care Provider

Print or Type

Employee name	Patient name (If a family member)

Nature of illness or injury:_____

_____

_____

Date condition commenced:_____	If hospitalized:
Date of treatment for this illness: _____	Date admitted: _____
Probable duration of condition:_____	Date discharged:_____
Are you the attending physician for this illness? _____Yes _____No	Was surgery scheduled: _____Yes _____No
If no, physician's name:_____	If yes, date of surgery:_____

Employee's condition

Is the patient still under your care for this condition _____Yes _____No

How long was or will the patient be unable to work:_____

Date patient can return to a regular work schedule:_____

If able to perform some work, is the employee able to perform any one or more of the essential functions of the employee's job? _____Yes _____No

If yes, list_____

Is it necessary for the employee to be absent from work for treatment or follow up visits?
_____Yes _____No

Will it be necessary to work intermittently or on a less than full schedule?
_____Yes _____No

If yes, give probable duration_____

Care for family member

Does the patient require assistance for basic medical or personal needs or safety, or for transportation?_____Yes _____No

Would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? _____Yes _____No

If the patient will need care only intermittently or on a part-time basis, indicate the probable duration of this need_____

Health Care Provider Name/Title (print)_____

Health Care Provider Signature_____Date_____