Hammonton School District
544 Old Forks Rd
Hammonton, NJ 08037
609-567-7000

SICK LEAVE BANK PHYSICIAN'S STATEMENT
Completion of this form is mandatory. No substitutes will be accepted.

TO BE COMPLETED BY PATIENT:

Patient's Name _____ Work Location_____

Home Address _____
_____

Authorization to Release Information: I hereby authorize the undersigned physician to release to the Sick Leave Bank Committee any information requested with respect to this claim.

Signature _____Date: _____

Date of Birth _____

1. What was the first day of absence from work due to this catastrophic, illness, accident or injury? Month _____ Day_____ Year_____

2. Have you ever had same or similar condition? [ ] Yes [ ] No If "yes", state when and briefly describe.

3. Is condition due to injury or sickness arising out of your employment? [ ] Yes [ ] No If "yes", describe.

TO BE COMPLETED BY PHYSICIAN
A. Physical Illness

1. Nature of Disability _____

2. Symptoms_____

3. Clinical findings (e.g., x-rays, lab data)_____

4. Treatment (e.g., surgery, medication)_____

    a. Period of hospitalization/Date of surgery_____

    b. Other confinement? Specify_____

5. Anticipated date of return to work. (**Must be completed**) _____

B. For all Disabilities

(***Must be completed or form may be returned without a decision from the Committee***)
What are patient's job related limitations?

a. temporary or permanent (please circle applicable term)

b. none, slight, moderate, severe (please circle applicable term)

This leave consists of days contributed by Hammonton employees, and may be used for catastrophic personal illness, accident, or injury only by the contributing member.

Physician's Name (Please print clearly)

_____ _____
Physician's Signature Date

_____
Please Print Physicians Name

_____

_____

_____

Address and Phone