



Sick Leave Bank Attending Physician's Statement

Patient's/Physician's Information:

Patient's Name: _____

Name of Physician Completing Form: _____

Physician's Phone Number: _____

Physician's Fax Number: _____

Authorization:

I hereby authorize Comal Independent School District to receive from and/or provide to medically related facilities and/or insurance companies, information as to any physician and/or mental condition of myself or the person named above as patient relating to this claim.

Signature: _____

Describe the injury or illness in detailed:

Would you define the patient's condition as catastrophic in nature? If so, please explain why?

Give Dates of Treatment: _____

To your knowledge, what is the earliest date this patient was treated for this condition?

Is patient still under your care?

Yes _____

No _____

How long was or will patient be continuously and totally unable to work? _____

Date patient can return to work: _____

Give dates hospitalized, if any, and name and address of hospital:

Date Admitted

Date Discharged

Name of Hospital

Address of Hospital

Date

Signature of Physician

Form SLB 4