Sick Leave Bank – Physician's Statement

TAAAC Sick Leave Bank Approval Committee
2521 Riva Road, Suite L7
Annapolis, Maryland 21401

Patient Will Complete

To Be Completed by Patient and Returned with Request Form by the Physician or the Patient

Patient's Name and Address *(Street, City, State, Zip Code)*:

Authorization to Release Information: I hereby authorize the designated physician to release to the TAAAC Sick Leave Bank Approval Committee pertinent information from my medical file gathered in the course of my examination or treatment.

Signature of Patient Authorizing Release	Date
Name of Physician	Telephone *(Area Code + No.)*

Address of Physician *(Street)* *(City)* *(State)* *(Zip Code)*

Physician Will Complete

To Be Completed By Physician *Clear, complete statement of the medical diagnosis confirming the qualifying condition of the patient and a list of job limitations the condition creates.*

Treatment Provided:

Please Complete the Appropriate Section Below:

1 Patient was under my care and disabled:

From: _____ To: _____

Please check one of the following:

2a ☐ It appears the patient will be able to return to teaching:

Date: _____

b ☐ It appears unlikely that this patient will be able to return to this type of employment

*Note: If you checked 2a, you **MUST** provide your best estimate of the date the patient will be able to return to teaching.*

Physician's Name (Print)	Telephone *(Area Code + No.)*
Physician's Signature	Date

Address *(Street)* *(City)* *(State)* *(Zip Code)*

Please Return To: *TAAAC Sick Leave Bank Approval Committee*
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STOP — No Sick Leave Bank days will be granted without receipt of this *completed* form.