3/25/2015

Sick Leave Bank
Physician's Statement

MCAAP

♦♦♦♦♦♦ **Montgomery County Association of Administrators and Principals**

TO BE COMPLETED BY PATIENT AND RETURNED TO MCAAP

Mr. ❒ Mrs. ❒ Miss ❒ Ms. ❒ Dr. ❒ (Check One)

Patient's Name: _____ Work Location: _____
First MI Last

Home Address: _____
No. Street City State Zip

Have you ever had the same or similar condition? Yes ❒ No ❒
If "yes," state when and describe. _____

Is condition due to injury or sickness arising out of your employment? Yes ❒ No ❒
If "yes," state when and describe. _____

Authorization to Release Information: I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment.

Signature: _____ Date: _____

TO BE COMPLETED BY PHYSICIAN

Detailed description of illness. (Failure to provide full and complete information will result in delay or denial of the requested grant.) _____

_____

_____

Recommended Treatment: _____

_____

_____

Was patient hospitalized? Yes ❒ No ❒ Dates: _____ to _____

Reason for hospitalization: Surgery _____ Illness _____ Tests _____ Out-Patient _____

Other (Explain): _____

Date patient should be able to return to work (Indefinite is not acceptable): _____

Is the patient able to perform all functions of their position? Yes ❒ No ❒

If No, explain: _____

Physician's Name (Please print): _____ Phone Number: _____

Signature: _____ Date: _____

Street Address: _____
No. Street City State Zip

ALL SECTIONS AND QUESTIONS MUST BE ANSWERED BEFORE SICK LEAVE BANK COMMITTEE WILL CONSIDER REQUEST FOR GRANT.

MCAAP – 30 West Gude Drive, Suite 100 - Rockville, MD 20850 – Office: (301) 762-8174 - Fax: (301) 762-8179