

EMERGENCY AUTHORITY ONLY
PHYSICIAN'S STATEMENT FOR EMPLOYEE
To be completed by the treating Physician



Provider Name: _____ Title: _____

Facility: _____

Address: _____

Phone Number: _____ Fax Number: _____

Employee Information:

Employee Name: _____ DOB: _____

INFORMATION BELOW TO BE PROVIDED BY PHYSICIAN

Our employee has submitted a request to receive leave donations. This program is used to supplement an employee's pay when they have a critical injury/illness that completely incapacitates their ability to work. Please provide the following information:

Date patient was unable to work due to illness/injury: _____

Expected date of return to full duty: _____

Check One

1. Is the condition critical in nature such that failure to provide immediate treatment could have resulted in loss of life or limb? Yes No

2. Was the condition unforeseeable or of a sudden onset? Yes No

3. Could the employee return to work with modified work schedule or restrictions? Yes No

If so, provide the date: _____ Hours per day: _____

Provider signature: _____ Date: _____

Sick Leave Bank applications are generally approved for the specified time as reported, if there is an extension of time requested, updated medical documentation must be provided for the extended period of time.