

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



Provider Name: _____ Title: _____

Facility: _____

Address: _____

Phone Number: _____ Fax Number: _____

Patient/Employee Information:

Patient Name: _____ DOB: _____

Employee Name: _____ Patient Relationship to Employee: _____

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 must remain off work to care for a family member who is incapacitated. Please provide the following information:

Date employee was unable to work due to family member illness/injury: _____

Expected date of return to full duty: _____

Check One

1. Was the condition unforeseeable or of a sudden onset? 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: _____

If the employee has already been away from work for 30 days or more, please answer the following:

4. Does the health condition of the family member continue to be critical in nature? Yes No

Provider signature: _____ Date: _____

Sick Leave Bank applications are generally approved for no more than 30 days at a time. Requests for Sick Leave Bank benefits in excess of 30 days require updated medical documentation for each request.