FLORIDA ATLANTIC UNIVERSITY
SICK LEAVE POOL
ATTENDING PHYSICIAN'S STATEMENT

NAME OF PATIENT:_____

EMPLOYEE ID NUMBER:_____

Statement of Patient: In support of my application for sick leave hours from the FAU Sick Leave Pool, I authorize all health care professional, including, but not limited to, physicians, psychiatrists, chiropractors, or any other examining health care professional, to release information concerning my illness/injury and any other pertinent data to the FAU Sick Leave Pool Committee.

_____ _____
Signature of Patient **Date**

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Physician's Statement

Please clearly print or type the requested information. Use additional sheets if necessary.

PHYSICIAN'S NAME_____ **License No.**_____

MAILING ADDRESS_____ **Phone No.**_____

_____

Date you first examined patient for this condition: _____

1. Name of referring health professional: _____ Phone No. _____

2. Diagnosis: _____

3. Current Condition: _____

4. A catastrophic illness or injury is defined as a severe condition or combination of conditions affecting the mental or physical health of an employee that has resulted in a life-threatening condition or has a *major impact on life-functions.*

Is the current condition Serious and/or Catastrophic? ☐ Yes ☐ No Please explain: _____

_____

_____

5. Course of Treatment: _____

_____

6. Can patient currently perform essential functions of job? (Please see attached position description)

_____

7. Prognosis _____

8. Anticipated date of return to work:

Limited Duty: _____

Full Duty: _____

_____ _____
Licensed Healthcare Provider's Signature Date

Return form To: Florida Atlantic University
Department of Human Resources
777 Glades Road, IS-4, Room 231
Boca Raton, FL 33431
Fax: (561) 297-1256