



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

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) 297-4220