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. 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:_________________________________

____ ________________________
Physician Signature Date

Return form To: Florida Atlantic University
Department of Human Resources
777 Glades Road, ADM 102
Boca Raton, Fl 33431
Fax: (561) 297-4220

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