PHYSICIAN'S STATEMENT
FACULTY ASSOCIATION OF SCHOOL DISTRICT 205
500 Armory Drive Suite 109 South Holland, IL 60473
(Please return to Ken Wendorff via e-mail or at the Faculty Association Office)

CONFIDENTIAL

SICK LEAVE BANK

TO THE PHYSICIAN:

Regulations of the Sick Leave Bank of the District 205 Faculty Association provide that a physician's certificate shall be furnished PRIOR TO GRANTING ANY REQUEST for benefits.

APPLICANT:
I request that the following medical statement be completed by my physician. I will forward the document to the Executive Director of the Faculty Association.

______________________________ ____
Date Signature of Applicant

STATEMENT OF PHYSICIAN

1. This is to certify that ____has been under my professional care
(Full Name of Patient)
since (date) ___________________________ and that I diagnosed his/her present condition as follows.
2. Diagnosis in full (attach additional pages if necessary):

____

____

☐ Check here if pregnant.

3. A. If pregnancy is the diagnosis, what is the anticipated date of birth? ______________________________
B. State the date the patient is able to return to work. ________________________________

4. A. Please state the anticipated duration of absence due to the illness. ______________________
B. Please state physical limitations. ____

5. What is the extent of physical activity allowed by the physician during the illness of the individual? Please be specific.

____

____

Does this activity include travel? Yes _____ No_____ If the answer is "yes", to what extent?

____

____

6. STATE REMARKS:

____

____

Physician's Name (Please Print) ____

Physician's Signature ____
Address ____
City ________________________________ **State** _________ **Zip** ______________
Telephone _____________________________ **Date** ______________