SICK LEAVE POOL ATTENDING PHYSICIAN'S STATEMENT

EMPLOYEE INFORMATION* (to be completed by the employee).
Complete the Employee Information portion below. The attending physician must fully complete the remainder of the form. A request for sick leave pool will **not** be considered until the **Attending Physician's Statement** is received.

Employee Name: _____

Campus/Dept.: _____ Date: _____

Patient's Name: _____ Relationship: _____

MEDICAL CERTIFICATION* (to be completed by the attending physician)
Please complete the following information regarding the patient named above.

Describe illness or injury in lay terms: _____

_____

Date of diagnosis: _____/_____/_____

Check all that apply:

The patient's illness, injury, or condition: ❒ is life threatening, ❒ requires in-patient hospitalization, and/or ❒ is expected to result in disability or death.

Explain the short-term prognosis: _____

_____

Explain the long-term prognosis: _____

_____

Dates of treatment: _____/_____/_____ End: _____/_____/_____

Is patient still under your care? ❒ Yes ❒ No

Hospitalization:

Name and address of hospital: _____

_____

Date admitted: _____/_____/_____ Date discharged: _____/_____/_____

Name of attending physician: _____

Address: _____

Phone: _____ Fax: _____

I certify that the information given on this Attending Physician's Statement is accurate and true.

Physician's Signature: _____Date: _____

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* Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).