Sick Leave Bank Request – Physician's Statement

Washington County Teachers Association (WCTA)
18047 Oak Ridge Drive ♦ Hagerstown, MD 21740
Telephone 301-797-7682 ♦ Fax 301-714-0450

INSTRUCTIONS: Attach Sick Leave Bank Physician's statement (2 pages) and forward all copies to WCTA.

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Physician's Statement Form ♦ Page 1

THIS SECTION TO BE COMPLETED BY PATIENT

Patient's Name: Last _____ First_____ MI_____

Address _____ City_____ State_____ Zip_____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned licensed medical doctor to release any information acquired in the course of my treatment or examination. If clarification is needed, I understand that it may be necessary to submit more medical statements at the Committee's request.

_____ _____

Applicant's Signature Date

THIS SECTION TO BE COMPLETED BY *TREATING* PHYSICIAN

NOTE TO PHYSICIAN: The purpose of this application is to provide sick leave to the above mentioned member of the WCTA Sick Leave Bank in case of a prolonged, incapacitating, and/or catastrophic personal illness. This information is necessary to allow the committee to render a fair and reasonable decision regarding whether or not this medical condition meets the criteria of the Sick Leave Bank. Both Physician Statement pages need to be completed.

Patient (name) _____was under my care and unable to work

from _____ / _____ / _____ through _____ / _____ / _____. **(Dates must be completed)**

Is this patient's condition a permanent disability? ☐ Yes ☐ No If yes, date known _____

Was surgery performed or is it scheduled to be performed? ☐ Yes ☐ No

- Surgery date _____ *If maternity, indicate date of birth*_____

Delivery type: vaginal ____ cessarean section ____

_____

Licensed Medical Doctor's Signature

_____ _____

Licensed Medial Doctor's Name (type or print MUST be legible) **Licensed Medial Doctor's Specialty**

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Physician's Statement Form ♦ Page 2

THIS SECTION TO BE COMPLETED BY *TREATING* PHYSICIAN

Please provide a complete statement of the medical diagnosis confirming the catastrophic and incapacitating nature of the condition. If it appears likely that this patient will not be able to return to this type of employment, please indicate below.

Patient's Name: Last _____ First _____ MI _____

TYPE OR PRINT LEGIBLY

Diagnosis: The physician's diagnosis, **in layman terms**, must include and confirm the **catastrophic and incapacitating** nature of this patient's condition.

_____

_____

_____

_____

Date physician diagnosed condition _____ Date treating physician last examined this patient _____

Treatment Plan: Briefly explain the treatment plan, including any medication adjustments and frequency of appointments and/or therapy.

_____

_____

_____

_____

Inability to Work: Please describe how this condition and its treatment inhibits the patient's ability to perform his/her professional duties.

_____

_____

_____

_____

Date patient is anticipated to return to work. * _____ **(Must be completed) ***The committee understands this may be adjusted.

_____

Licensed Medical Doctor's Signature (Please include M.D., D.O., etc.)

_____

Licensed Medical Doctor's Name (type or print – **MUST** be legible)

_____

Licensed Medical Doctor's Specialty

Telephone / Preferred Contact (Email or Other)

Address of Physician (Street, City, State, Zip)