KNOX COUNTY SCHOOLS
ANDREW JOHNSON BUILDING

CLASSIFIED SICK LEAVE BANK
PHYSICIAN STATEMENT

Name (As listed on Social Security Card):

_____ Social Security No. _____
Last First Initial

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the undersigned physician to release any information required in the course of my examination or treatment to the Trustees of the Non-Certified Sick Leave Bank.

_____ _____
Date *Applicant's Signature*

TO BE COMPLETED BY PHYSICIAN
(Must Be Legible and Fully Completed)

Original Diagnosis Date _____

Date of Surgery _____

Diagnosis of Illness or Injury (layman's terms, please) _____

_____

_____

Is absence due to elective surgery/procedure? ☐ Yes ☐ No Elective surgery includes but is not limited to: (1) Radial keratotomy and other surgical procedures to correct refraction error(s). (2) Any operation relating to the fitting or wearing of dentures or teeth. (3) Cosmetic surgery unless as a result of injury or illness. (4) Experimental surgical procedures not yet recognized as acceptable medical practice or which require, but have not received, approval of federal or other governmental agency. (5) Reversal of sterilization procedures. (6) Surgery to change sex and related treatment. (7) services or supplies in connection with artificial insemination, in-vitro fertilization or any procedure intended to create a pregnancy. (8) Pregnancy.

Patient is under my care:

From: _____ Until _____
M / D / Y M / D / Y

Dates Patient unable to work due to this illness and injury:

From: _____ Until _____
M / D / Y M / D / Y

Physician Name (Print): _____

Address: _____
Street City/State Zip

Office Telephone Number: _____

_____ _____ _____
Today's Date Name of Physician Group Physician **Original** Signature

Please mail the original form to the Sick Leave Bank Office as soon as possible.
Xerox or faxed copies are not acceptable.
Any corrections/changes on form must be initialed by physician.

BO–162 (4/11)