

HCEA-ESP Sick Leave Bank Request – Physician’s Statement

Harford County Education Association (HCEA)
c/o Harford County Public Schools
102 S. Hickory Avenue • Bel Air, MD 21014
Telephone (410) 588-5254 • Fax (410) 588-5309

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

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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 HCEA-HCPS Sick Leave Bank in case of a prolonged, incapacitating and 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 _____

Licensed Medical Doctor’s Signature

Licensed Medical Doctor’s Name (type or print MUST be legible)

Licensed Medical 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

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

Both Physician Statement Forms must be completed and signed by the Licensed treating physician.