HCEA 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: 410-588-5225 ~ www.hcps.org

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

CONFIDENTIAL

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 treating physician to release information for this condition to an authorized representative of the Sick Leave Bank Committee obtained during my treatment or examination that is necessary to evaluate my Sick Leave Bank request.

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: This request provides Sick Leave Bank benefits for a prolonged, incapacitating, and catastrophic personal illness. Please provide all pertinent information, in layman's terms, demonstrating how the patient's condition meets these criteria and impacts their ability to work. The Committee relies on this information to determine eligibility. Both pages of the Physician's Statement must be completed in full.

Patient Name: _____ was under my care and unable to work from _____/_____/_____ through _____/_____/_____. **(Dates must be completed)**

Anticipated Return to Work Date. *_____ **(Must be completed)** *The committee understands this may be adjusted.

Is this patient's condition a permanent disability? ☐Yes ☐No If yes, does the permanent nature of the disability mean the patient is permanently unable to perform the **essential duties of their current position**? ☐Yes ☐No If yes, please explain:

_____

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

_____

_____

_____

_____

_____ _____

Licensed Treating Physician's Signature **Licensed Treating Physician's Specialty**

_____ _____

Licensed Treating Physician's Name **(Type or Print-MUST be legible)** **Date of Treating Physician's Signature**

CONFIDENTIAL

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 laymen 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: _____

Was surgery performed or is it scheduled to be performed? ☐Yes ☐No If yes, surgery date: _____

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

_____

_____

_____

_____

_____

Licensed Treating Physician's Signature (Please include M.D., D.O., etc.)

_____

Date of Licensed Treating Physician's Signature

_____

Licensed Treating Physician's Name (type or print – MUST be legible)

_____

Licensed Treating Physician's Specialty

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

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