SAN ANGELO INDEPENDENT SCHOOL DISTRICT

Catastrophic Sick Leave Bank

Certification of Health Care Provider

Print or Type

Employee name	Patient name (if different from employee)

Diagnosis (nature of illness or injury)

Date condition commenced _____ Probable duration of condition _____ Are you the attending physician for this illness? ☐ Yes ☐ No If no, physician's name _____ Is patient still under your care for this condition? ☐ Yes ☐ No	If hospitalized Date admitted _____ Date discharged _____

Employee's condition

Is the employee unable to perform work of any kind? ☐ Yes ☐ No

If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job? ☐ Yes ☐ No

Is yes, list_____

Is it necessary for the employee to be absent from work for treatment? ☐ Yes ☐ No

Will it be necessary to work intermittently or on a less than full schedule? ☐ Yes ☐ No

If yes, give probable duration_____

Care for family member

Does the patient require assistance for basic medical or personal needs or safety, or for transportation? ☐ Yes ☐ No

If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? ☐ Yes ☐ No

If the patient will need care only intermittently or on a part-time basis, indicate the probable duration of this need_____

Date patient can return to a regular schedule (i.e. work/school)

Health Care Provider Name/Title (print)_____

Health Care Provider Signature_____Date_____