

DENVER CITY INDEPENDENT SCHOOL DISTRICT
Denver City, Texas

Sick Leave Bank
Attending Physician's Statement

Name of patient: _____

Name of DCISD employee: _____
(if different from the name of patient)

Nature of sickness or injury:

Dates of treatment: _____

Dates hospitalized, if any, and name and address of hospital:

Date admitted: ___/___/___ Date discharged: ___/___/___

Name of hospital: _____

Address: _____

To your knowledge, what is the earliest date the patient was treated for this condition?

Is patient still under your care? Yes _____ No _____

For what period of time will the patient be unable to work?

For what reason(s) would the patient need to miss work for this long?

Date patient can return to work? _____

Typed or printed name of physician

Signature of physician

Date