Verification of Sickness – Practitioner's Report

The information provided will be used solely to verify the employee's claim for sick leave.

Part 1: Employee Identification and Authorization

_____

Last Name First Name Initial

I hereby authorize the release of the information requested in Part 2 below to the relevant administrative personnel of the Board of Education of the Northwest School Division to verify this claim for sick leave.

_____

Employee's Signature Date of Birth (D/M/Y) Date (D/M/Y)

Part 2: Attending Practitioner's Statement to Verify Sickness

1. Date of consultation: _____ (D/M/Y)
2. The above named employee has been incapable of fulfilling his/her duties due to sickness:
   a) from _____ (D/M/Y) to _____ (D/M/Y), **OR**
   b) since _____ (D/M/Y) **AND** will be incapable of fulfilling duties:
      i. for less than 4 weeks until _____ (D/M/Y); **OR**
      ii. until expected date of return _____ (D/M/Y); **OR**
      iii. for at least: __4 weeks ___6 weeks ___3 months ___6 months __12 months
3. Date of next medical review: _____ (D/M/Y)
4. Has treatment been prescribed? _____ Yes _____ No

Physician's Signature:

_____

Date: _____

Telephone: _____

Physician's Name and Address:
Please print or use stamp)

_____

_____

_____

Costs associated with the completion of this form to be borne by the employee.

Northwest School Division #203

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