Roane State Community College Faculty Sick Leave Bank Physician's Certification Form

Patient name: _____

The following information is to be provided by the attending physician. (Please **print** or **type** in legible layman terms.)

Treatment:_____

Date of surgery or emergency treatment: _____

Date of follow-up appointment : _____

Expected duration of disability: _____

Prognosis: _____

Estimated date of return to work: _____

Is this treatment/surgery due to a recurring condition? Yes _____No_____

Please use this space for additional comments. _____

Employee (or FSLB Chairman) Signature Date

Print Physician/Surgeon Name: _____

Name of Practice: _____ Phone #_____

Physician/Surgeon Signature Date

5/2015