LCSD Support Staff Verification of Sickness – Practitioner's Report

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

Part 1: 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 **Lloydminster Catholic School Division** to verify claim for sick leave.

SUPPORT STAFF 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 support staff has been incapable of fulfilling regular 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: _____ Physician's Name and Address:
(Please print or use stamp)

Date: _____ _____

Telephone: _____ _____

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

Return the completed form to your employing school board.