# DOCTOR'S CERTIFICATE SICK LEAVE BANK

This complete certificate is required before a member may use his/her sick leave bank entitlement.

To be completed by Employee:

NAME_____

POSITION_____

SCHOOL_____

Reason for Leave:
Employee Illness _____ Family Illness _____ (State Relationship) _____

To be completed by Physician:

DETAILED DESCRIPTION OF ILLNESS _____

_____

_____

_____

Estimated time away from work: _____

I hereby certify the above named employee of Scott County Public Schools is totally unable to work due to the illness or disability indicated above and will be able to return to work on _____.

_____
Physician's Signature

ADDRESS: _____

_____

_____

PHONE: ( ) _____

DATE:_____

I recommend/do not recommend approval of this sick leave bank utilization.

_____
Advisory Committee