

**LHISD SICK LEAVE BANK ATTENDING PHYSICIAN'S STATEMENT**

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**EMPLOYEE INFORMATION\*** (to be completed by the employee).

Complete the Employee Information portion below. The attending physician must fully complete the remainder of the form. A request for sick leave bank days will **not** be considered until the **Attending Physician's Statement** is received.

Employee Name: \_\_\_\_\_

Campus/Dept.: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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**MEDICAL CERTIFICATION\*** (to be completed by the attending physician)

Please complete the following information regarding the patient named above.

Describe illness or injury in lay terms: \_\_\_\_\_

\_\_\_\_\_

Date of diagnosis: \_\_\_\_/\_\_\_\_/\_\_\_\_

Check all that apply:

The patient's illness, injury, or condition:  is life threatening,  requires in-patient hospitalization, and/or  is expected to result in disability or death.

Explain the short-term prognosis: \_\_\_\_\_

Explain the long-term prognosis: \_\_\_\_\_

\_\_\_\_\_

Dates of treatment: \_\_\_\_/\_\_\_\_/\_\_\_\_ End: \_\_\_\_/\_\_\_\_/\_\_\_\_

Is patient still under your care?  Yes  No

**Hospitalization:**

Name and address of hospital: \_\_\_\_\_

\_\_\_\_\_

Date admitted: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date discharged: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of attending physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**I certify that the information given on this Attending Physician's Statement is accurate and true.**

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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\* **GINA NONDISCLOSURE NOTICE:** The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or

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received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.