HCEA Sick Leave Bank Extension Request

Howard County Education Association (HCEA)
Dorsey Hall Professional Park
5082 Dorsey Hall Drive ● Suite 102 ● Ellicott City, Maryland 21042
Telephone 410-997-3440 ● Fax 410-997-3443 ● Email HCEASLB@mseanea.org

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Physician's Statement Form ● Page 1 of 2

THIS SECTION TO BE COMPLETED BY PATIENT

Patient's Name: Last _____ First _____ MI ____

Address _____ City _____ State _____ Zip _____

Home Phone Number _____ Cell Phone Number _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned licensed medical doctor to release any information acquired during my treatment or examination. If clarification is necessary, I understand that it may be necessary to submit more medical statements at the Committee's request or I hereby authorize the Sick Leave Bank Administrator to speak directly to the doctor's office. I agree to provide the job analysis found at HCEANEA.ORG to the physician completing this form.

_____ _____

Applicant's Signature Date

THIS SECTION TO BE COMPLETED BY *TREATING* PHYSICIAN

NOTE TO PHYSICIAN: The purpose of this application is to provide sick leave to the above-mentioned member of the HCEA-HCPSS Sick Leave Bank in case of a prolonged, incapacitating and catastrophic personal illness. This information is necessary to allow the committee to render a fair and reasonable decision whether this medical condition meets the criteria of the Sick Leave Bank. Both Physician Statement pages need to be completed.

Patient (name) _____ was under my care and unable to work from _____ / _____ / _____ through _____ / _____ / _____. (**Dates must be completed. If end date is unknow, please write an estimated date the patient is expected to return to work.**)

Is this patient's condition a permanent disability? ☐ Yes ☐ No If yes, date known _____

Was surgery performed or is it scheduled to be performed? ☐ Yes ☐ No If yes, date of surgery _____

If surgery was performed, the following **MUST** be completed:

Is/Was the surgery: Check one (√) ☐ Medically advised at this time ***or*** ☐ Able to wait until school is not in session/system break

_____

Licensed Medical Doctor's Signature

_____ _____

Licensed Medical Doctor's Name (type or print – MUST be legible) Date

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THIS PAGE TO BE COMPLETED BY *TREATING* PHYSICIAN

Please provide a complete statement of the medical diagnosis confirming the catastrophic and incapacitating nature of the condition. If it appears likely that this patient will not be able to return to this type of employment, please indicate below.

Patient's Name: Last _____ First _____ MI _____

TYPE OR PRINT LEGIBLY

Diagnosis: The physician's diagnosis, **in layman terms**, must include and confirm the **catastrophic and incapacitating** nature of this patient's condition.

_____

_____

_____

_____

Date physician diagnosed condition _____ Date treating physician last examined this patient _____

Treatment Plan: Extension requests require the treatment plan to be updated to reflect where the patient is currenlty in their recovery (ie. Please do not submit the same plan unless the patient has made no improvement). If writing an addendum is more efficient in explaining the patient's current status, please feel free to do so.

_____

_____

_____

_____

Inability to Work: Please describe how this condition and its treatment inhibits the patient's ability to perform his/her professional duties during the workday. Unless the position is itinerant, this may not include driving limitations.

_____

_____

_____

_____

Date patient is anticipated to return to work. * _____ **(Must be completed and match date on page 1 of Physician's Statement Form)**

*The committee understands this may be adjusted.

_____

Licensed Medical Doctor's Signature (Please include M.D., D.O., etc.)

_____

Licensed Medical Doctor's Name (type or print – **MUST** be legible)

_____

Date

Both Physician Statement Forms must be completed and signed by the licensed treating ***physician.***

Required: Address of Physician (Street, City, State, Zip)

Physician's Telephone: