CHARLOTTE COUNTY PUBLIC SCHOOLS

PHYSICIAN STATEMENT

(FOR EMPLOYEES RECEIVING TRANSFERRED SICK LEAVE)

Patient's Name: _____

Physician's Name: _____ Phone: _____

Firm Name: _____ Fax: _____

Address: _____
Street City Zip

DATE OF VISIT _____ _____

EXPECTED DATE OF RETURN TO WORK _____

FOLLOW UP EXAM DATE_____

PHYSICIAN'S SIGNATURE_____ DATE_____

Physician, please return this form to the patient

****In accordance with Florida statutes, a physician statement form must be submitted with your leave form to use transferred sick leave.****