CLINTON MASSIE LOCAL SCHOOL DISTRICT
SICK LEAVE DONATION PROGRAM APPLICATION
ATTENDING PHYSICIAN'S STATEMENT

Patient's Name: ________________________________ D.O.B. ______________________

What is the precise nature of the illness or injury?

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What is the diagnosis/prognosis?

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What is the projected date of return to work? ____

Remarks:

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Date: ____________________

Signed: ____
(Attending Physician)

Address: ____

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This form must be completed and returned with the sick leave donation program application in order to process the request.