

**SICK LEAVE BANK MEDICAL CERTIFICATE FORM**

***\*\*Sick Leave Bank days may be granted only for instances of disability illness, injury, or quarantine of the individual member of the member's immediate family as defined by policy 03.12321. Grants of sick leave from the Sick Leave Bank shall not be made to any member for the purpose of undergoing elective surgery or during any period the member is receiving disability benefits from Kentucky Teachers Retirement.\*\****

Name of Patient: \_\_\_\_\_

Name of Physician: \_\_\_\_\_

Physician's Specialty: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Date patient needs to be (or was) confined to hospital, other medical facility, or home:  
Anticipated beginning: \_\_\_\_\_ Ending: \_\_\_\_\_

Type of illness or injury: \_\_\_\_\_

1) In your medical opinion, does this illness/injury prevent the employee from performing his/her regular duties? \_\_\_\_\_

2) In your medical opinion, are there any job duties the patient could perform?  
\_\_\_\_\_

3) How long has this patient been under your care? \_\_\_\_\_

4) Do you see this patient on a regularly scheduled basis? \_\_\_\_\_

5) In your medical opinion, when is the patient expected to return to work? \_\_\_\_\_

6) Is there any other information you can share with the Sick Leave Bank committee that would assist us in making a determination for this request? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby certify that it is/was medically necessary for the above patient to be confined to hospital, other medical facility, or home as stated above.

Doctor Signature \_\_\_\_\_

*Attach this form to the Sick Leave Bank Usage Application and return it to Valerie Rich at the Central Office*