

Form 455.2 LCSD Support Staff Verification of Sickness – Practitioner’s Report

The information provided will be used solely to verify the claim for sick leave.

Part 1: Identification and Authorization

LAST NAME	FIRST NAME	INITIAL
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I hereby authorize the release of the information requested in Part 2 below to the relevant administrative personnel of the Board of Education of the Lloydminster Catholic School Division to verify claim for sick leave.

SUPPORT STAFF SIGNATURE	DATE OF BIRTH (D/M/Y)	DATE (D/M/Y)
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Part 2: Attending Practitioner’s Statement to Verify Sickness

1. Date of consultation: _____(D/M/Y).
2. The above-named support staff has been incapable of fulfilling regular duties due to sickness:
 - a) From _____(D/M/Y) to _____(D/M/Y), **OR**
 - b) Since _____(D/M/Y) **AND** will be incapable of fulfilling duties:
 - (i) For less than 4 weeks until _____(D/M/Y) **OR**
 - (ii) Until expected date of return _____(D/M/Y) **OR**
 - (iii) For at least:
 4 weeks 6 weeks 3 months 6 months 12 months
3. Date of next medical review: _____(D/M/Y).
4. Has treatment been prescribed: Yes No

Physician’s Signature: _____

Physician’s Name and Address:
(Please print or use stamp)

Date: _____

Telephone: _____

Costs associated with the completion of this form to be borne by the support staff.

Return the completed form to your employing school board.