SHARED VACATION DONATION
PHYSICIAN'S STATEMENT

Please print legibly.

Patient's Full Name: _____

Address: _____

City: _____ State: _____ Zip Code _____

Home Phone: _____ Employee ID#: _____ Birth Date: _____

I authorize you to complete the lower section of this form so I can apply for additional leave time.
I also authorize you to release information pertinent to this request.

Signature: _____ Date: _____

Physician's Statement

Diagnosis: _____

Symptoms: _____

What is this condition primarily related to? _____

_____

When do you anticipate the patient can return to work? Date: _____

Describe the patient's physical/mental limitations and work activity restrictions: _____

_____

Is this a life threatening or debilitating physical illness or injury which prevents the employee from performing the duties of their job for more than ten [10] working days? [ ] Yes [ ] No

Physician completing the form: _____ Office #: _____
Name of Physician

Address: _____ City: _____ Zip Code: _____

Signature: _____ Date: _____

Please return completed form to:
Association of Salem Keizer Education Support Professionals
2540 Coral Avenue NE | Salem, OR 97305
[office] 503.364.8612 [facsimile] 503.364.6988

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