Okeechobee County School Board
Employees Sick Leave Bank Program
Medical Certificate

Employee Name _____

Address _____
Street/P.O. Box City State Zip Code

Physician's Name _____ Office Phone _____

Address _____
Street/P.O. Box City State Zip Code

I authorize my physician, _____, to release information pertaining to my medical condition as indicated on this certificate to my employer, Okeechobee County School Board. This information will be used to determine my eligibility to be paid from an employer-sponsored Sick Leave Bank as a result of my medical disability.

_____ _____
Employee's Signature Date

Please describe the nature of the illness or injury: _____

_____

_____

_____

If surgery is indicated, is it necessary at this time? ❑ Yes ❑ No

If yes, please explain: _____

_____

Does the illness or injury described above disable the patient from performing their regularly assigned job? ❑ Yes ❑ No

Please explain: _____

_____

_____

Applicant can return to work on or about _____
Date

_____ _____
Physician's Signature Date