FLORIDA ATLANTIC UNIVERSITY
SICK LEAVE POOL
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NAME OF PATIENT:____

EMPLOYEE ID NUMBER:____

Statement of Patient: In support of my application for sick leave hours from the FAU Sick Leave Pool, I authorize all health care professional, including, but not limited to, physicians, psychiatrists, chiropractors, or any other examining health care professional, to release informa75.34 30 618tg 2.34 30n.(r)] TJ ET Q q 0.00000912 0 6M2 0 692(hi)-3 Qt.(rn5>3<07 Q

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e condition or combination of conditions affecting the mental or physical health of an employee that has resulted in a life-threatening condition or has a major impact on life

Can patient currently perform essential functions of job? (Please see attached position description)

____

7. Prognosis ____

8. Anticipated date of return to work:

Limited Duty: ________________

Full Duty: ________________

____ ______________________
/LFHQVHG +HDOWKFDUH 3URYLGHU¶V 6LJQDWXUH Date

Return form To: Florida Atlantic University
Department of Human Resources
777 Glades Road, IS-4, Room 231
Boca Raton, FL 33431
Fax: (561) 297-1256

Rev01/20

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