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

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)

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.