Houston Independent School District
Leave Administration
Hattie Mae White Educational Support Center
4400 West 18th St., Houston, TX 77092
Ph: 713-556-6590 ◈ Fax: 713-556-6966 ◈ Email: LeaveAdministration@HoustonISD.org

Supplemental Sick Leave Bank (SSLB) Benefit Claim Form II: Confidential Attending Physician's Statement

HISD EMPLOYEE			
Last Name:		First Name:	
Home Address:		SSN #:	
Phone #:		Employee ID:	

I hereby authorize my medical practitioners, facilities, and other entities as necessary to release my medical and mental health information to the HISD Benefits/Leave Administration department as relevant to this claim. I understand I have a right to receive a copy of this authorization, and agree a copy is as valid as the original.

Employee Signature: _____ **Date**: _____

PHYSICIAN				
Required For All Patients				
Is patient currently under your care?				❑ Yes ❑ No
Based on my medical diagnosis or opinion, the patient's medical condition is severe enough to require the patient's **absence from work for a minimum of seven (7) consecutive workdays**?				❑ Yes ❑ No
Physician's recommended date for patient to **stop** working:				____/____/____ month / day / year
Physician's recommended date for patient to **return** to work:				____/____/____ month / day / year
ICD-10 CODE(s):				
****REQUIRED**** Provide additional relevant information **not** identified by ICD-10 codes:_____				

Only Complete For Pregnancy And Childbirth Absences:			
Are absences related to pregnancy or childbirth?			❑ Yes ❑ No
Is patient's condition atypical of a normal pregnancy or childbirth?			❑ Yes ❑ No
If yes, are complications atypical of a normal:	❑ Gestation	❑ Delivery	❑ Post-partum Recovery
Was delivery by (or expected to be) a cesarean section?			❑ Yes ❑ No

Only Complete For Ongoing Care/Treatment Requiring Intermittent Work Absences:		
Provide period of intermittent absences:	From: ____/____/____ month / day / year	To: ____/____/____ month / day / year
Provide frequency of absences (daily, weekly, etc.):		
Expected length of each absence (in hours):		

By signing below, I confirm the information provided on this form by my staff and I is true and accurate to the best of my knowledge, and based on the medical diagnosis or opinion, the work absences are medically warranted.

Physician Signature:_____ **Date**: _____

Print Physician Name:_____ **Phone #**: _____

Office Address:_____ **Fax #**: _____