Salt Lake Community College

Sick Leave Pool Application

Licensed Practitioner Statement

I authorize my licensed practitioner, _____,
to release any information requested on this form and any other pertinent information concerning my condition to Salt Lake Community College's Sick Leave Pool Administrator.

_____ _____ _____

Name Patient's signature Date

The employee has applied to the College's sick leave pool for benefits. The information requested will be used solely to determine the employee's eligibility for benefits and, if eligible, the number of days awarded to the employee.

What is the severe condition or combination of conditions? In the case of mental health conditions, please provide a Global Assessment of Functioning (GAF) score.

Was the treatment elective? ☐ Yes ☐ No

Please provide anticipated treatment dates and schedule of treatments.

Would the severe condition or combination of conditions result in death if not treated promptly? ☐ Yes ☐ No

If yes, please explain:

Did the severe condition or combination of conditions require hospitalization for more than 72 consecutive hours?

If yes, please provide dates:

How long will the severe condition or combination of conditions prevent this patient from working?

Any additional information from the outpatient visit or otherwise:

Date patient was last examined as an outpatient _____

_____ _____

Licensed Practitioner Name Phone

_____ _____

Licensed Practitioner signature Date