

LEON COUNTY SCHOOLS CERTIFICATION OF PHYSICIAN OR PRACTITIONER SICK LEAVE TRANSFER BETWEEN LCSB EMPLOYEES

To Be Completed By Employee

Employee Name:	
Employee SS #:	Cost Center #:
Patient's Name (If other than employee):	
Employee Signature	Date
To Be Completed By Physician or Prac	titioner
Nature of Illness:	
Date condition commenced:Probal	ble duration of condition:
Physician/Practitioner Signature	Date
Typed or Printed Name of Physician or Practitioner:	
Type of Practice (Field of Specialization, if any):	

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