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 Practitioner

Nature of Illness: _____

_____

Date condition commenced: _____ Probable duration of condition: _____

_____ _____

Physician/Practitioner Signature **Date**

Typed or Printed Name of Physician or Practitioner: _____

Type of Practice (Field of Specialization, if any): _____