WAYNE TOWNSHIP PUBLIC SCHOOLS
PHYSICIAN'S STATEMENT/SICK LEAVE REQUEST
(NON-MATERNITY RELATED)

PART I

PHYSICIAN'S CERTIFICATION OF ANTICIPATED ILLNESS/CONVALESCENCE DATE(S)

TO: Physician of ____
(Name of Employee)

The above named is an employee of the Wayne Township Public Schools and is anticipating an absence from work due to illness/convalescence and is entitled to certain health benefits from the district during her/his absence.

In order to properly administer the public funds of the school district and to provide all of the benefits to the employee to which s/he is legally entitled, it is necessary that the employee submit this certification.

Please complete **PART I** of the form and return it to the employee.

I hereby certify that an examination of the person named above was administered by me. ________________________________ will be required to be absent from work from _____________ through __________________________.

____ ______________ ______________________
Medical Examiner's **SIGNATURE** **Date** **License or Narcotic No.**

____
Print **NAME**

____ ______________________
Print **ADDRESS** **Telephone**

____

(Part II must be completed by employee)

PART II

EMPLOYEE'S REQUEST FOR SICK LEAVE USING ILLNESS DAYS

NAME ____

Address ____ Telephone # ___________________

Present Assignment __________________________________ School _______________________

Number of accumulated sick leave days _______________ as of _________________ .

I wish to begin use of my accumulated sick leave on _______________________.

I want my accumulated sick leave to end (or) I plan to return to work on ___________________.
(date)

The employee must notify her/his Building Administrator (Principal) and HR if the actual dates is/will be different from the anticipated dates previously expected.

____ ________________
Employee Signature Date

____ _________________
Building Administrator Signature Date

____ _________________
Director of Human Resources Date