SHARED VACATION DONATION
PHYSICIAN'S STATEMENT

Please print and legibly
Patient's Full Name: _____

Address: _____

City _____ State _____ Zip _____

Home Phone _____ Employee ID # _____ Birth Date _____

I authorize you to complete the lower section of this form so I can apply for additional Leave time. I also authorize you to release information pertinent to this request.

Signature: _____ Date _____

Physician Statement:

Diagnosis: _____

Symptoms: _____

What is this condition primarily related to? _____

_____

When do you anticipate the patient can return to work? Date: _____

Describe the patient's physical and mental limitations and work activity restrictions:

_____

_____

Is this a life threatening or debilitating physical illness or injury which prevents the employee from performing the duties of his/her job more than ten (10) working days?

Yes _____ or No _____

Physician completing this form: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Signature: _____ Date: _____

Please return completed form to:
Association of Salem Keizer Education Support Professionals (ASK ESP)
PO BOX 17038
Salem OR 97305

Phone (503) 364-8612
Fax (503) 364-6988