Licensed Practitioner's Statement

In Support of an Application to Withdraw Hours
From the Sick Leave Pool.

I authorize my licensed practitioner,_____,
to release the information requested on this form, and/or any additional relevant information concerning my health condition, to the Sick Leave Pool Administrator at The University of Texas at Dallas.

Patient's Signature:_____

Date:_____

Patient's Printed Name:_____

Employee's Printed Name (if different than Patient's Name):_____

The employee identified above has applied to the University'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.
1. What is your diagnosis of the severe condition or combination of severe conditions affecting this patient?
2. Do you consider the treatment to be elective? _____Yes _____No
3. Will this severe condition or combination of severe conditions result in death if not treated promptly? _____Yes. _____No. If yes, please explain:
4. Has this severe condition or combination of severe conditions required hospitalization for more than 72 consecutive hours? _____Yes _____No. If yes, please provide dates:
5. Probable duration of severe condition or combination of conditions?
6. Date patient was last examined:
7. Additional Information, if any, Practitioner, believes would assist in the evaluation of employee's request for benefits:

Office Telephone Number:	Office Fax Number:
Licensed Practitioner Signature:	Date: