



THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT SAN ANTONIO

SICK LEAVE POOL PROGRAM

ATTENDING PHYSICIAN STATEMENT FORM

1. Name of Employee (Patient):

Last First M.I.

2. Date When Symptoms First Appeared or Injury Occurred: _____

3. Date of First Doctor's Visit: _____

4. If Pregnancy, State the Estimated Date of Delivery: _____

5. a) Indicate if Employee Is (check one):
- Bed Confined
 - Home Confined
 - Hospital Confined
 - None of the Above

b) If Hospital Confined, Enter Admission and Discharge Dates: _____ to _____

6. Diagnosis (include ICD-9 code): _____
ICD-9 DESCRIPTION

7. Prognosis (include approximate date employee is expected to return to work):

8. Name of Attending Physician (please print or type): _____

Address City, State, Zip Code, Phone Number

Attending Physician's Signature Date