99 Corliss Street
Providence, RI 02904

Phone: (401) 421-4014
Fax: (401) 421-9239

Medical Certification by Attending Medical Provider

Applicant Name: ______________________________________

Social Security No.:______________________________________

Address: ______________________________________ Phone No.: ____________________

______________________________________ Email: ______________________

Please certify the nature of the illness/injury, the amount of time that you anticipate that the applicant will be absent from work, the prognosis and/or treatment, and the anticipated date of return to work.

Diagnosis:

____

____

____

Prognosis/Treatment:

____

____

____

Anticipated date of return to work: ______________________________
(month, day & year)

______________________________________ ______________________________
Signature of Medical Provider Date

Medical Provider Name & Address (Please Print) **Office Phone Number**

______________________________________ ______________________________

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EMERGENCY SICK LEAVE BANK

RELEASE OF MEDICAL INFORMATION

(Please print or type all required information)

I, ____, authorize
(Last Name) (First Name) (Middle Initial)

____
Name of Licensed Medical Provider Office Phone #

____
Licensed Medical Provider Address

to release medical information to the Providence Teachers Union Emergency Sick Leave Bank Committee, including but not limited to, the nature of my illness/injury, the amount of time that I am expected to be absent from work, my prognosis and/or treatment and my anticipated date of return to work.

______________________________ ____________________
(Signature) (Date)

Providence Teachers Union
99 Corliss Street
Providence, RI 02904