Providence Teachers Union
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 Physician Office Phone #

_____
Office Address of Physician

To release medical information to the Providence Teachers Union Emergency Sick Leave Bank, 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 the anticipated date of my return to work.

_____
Signature of Applicant Date

Providence Teachers Union
99 Corliss Street
Providence, RI 02904