ROCK HILL SCHOOL DISTRICT THREE OF YORK COUNTY
Personnel Department
P. O. Drawer 10072
Rock Hill, South Carolina 29731
(803) 981-1024 (Phone)
(803) 981-1025 (Fax)

SICK LEAVE BANK – PHYSICIAN'S CONFIRMATION

Regarding: _____
Name of Employee

_____
Employee Work Location

_____
Name of Patient/Relationship to Employee

I hereby certify that the above named employee (or employee's spouse or child) has been under my care for treatment of _____ which has required that the employee miss work for an extended period. The employee should be able to return to performance of duties associated with his/her job on or about (date) _____.

Physician: Please include below a detailed description of the nature of the condition for which you are treating this patient to explain why this condition would be considered catastrophic (severe incapacitation/inability to work). If additional space is needed, please attach it to this form.

_____
_____
_____
_____
_____
_____
_____

_____
Signature of Attending Physician

_____
Date

Please return to:
Personnel Office
Rock Hill School District Three
P. O. Drawer 10072
Rock Hill, South Carolina 29731