GCCG-ED

EXHIBIT

STAFF VOLUNTARY
TRANSFER OF ACCRUED SICK LEAVE

(Sick Leave Bank)
PHYSICIAN'S STATEMENT

Name of Patient _____

Please describe the nature of illness or disability and explain any extenuating circumstances that would be helpful to the Sick Leave Bank Committee:

Duration of the illness:

Actual _____ to _____

Estimated _____ to _____

I certify that this illness/disability renders this Window Rock Unified School District No. 8 employee incapable of performing his/her normal assigned duties or necessitates the employee's care of a family member.

_____ _____

Physician Signature Date

Please return this form to the above-named patient or to:

Window Rock Unified School District No. 8
Business Office
Post Office Box 559
Fort Defiance, AZ 86504