Benton School District

Jeff Collum, Superintendent
P.O. Box 939
Benton, AR 72018

Statement of Claim
Sick Leave Bank Benefits

EMPLOYEE'S STATEMENT

Instructions:
1. **Please make sure all questions on Employee's statement are completed in full.**
2. **Physician Statement on reverse side must be completed.**
3. **Claim form must be signed and currently dated.**

Full Name ______________________ Social Security Number ______________________

Address ______________________ Telephone Number ______________________

Date of Birth ______________________ Occupation ______________________

Nature of Illness or disability ______________________ Date of 1st Treatment ______________________

Names and addresses of all doctors consulted for this condition (Use separate sheet if necessary):

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Employee Signature ______________________ Date ______________________

Please have your Attending Physician complete the reverse side.

PHYSICIAN MUST FAX TO 501-776-5794

Revised 8-29-2011

ATTENDING PHYSICIAN'S STATEMENT

Exact Diagnosis and Concurrent Conditions
1.
2.
3.

Date Symptoms First Appeared____________________

Date Patient First Consulted You____________________

Cause of illness and/or disability____________________

Prognosis____________________

Type of treatments, current treatments, diagnostic testing, dates and results:____________________

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List the frequency of episodes____________________

Date of the last episode____________________

How long will patient be unable to work?
From____________________ Through____________________

Can return to work on ____________________

Has Patient Ever Had Same or Similar Conditions and/or Disabilities?
__________No __________Yes, Date____________________

Describe any circumstances causing condition and/or disability to be prolonged:____________________

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Date of Next Appointment and/or Treatment____________________

____________________ ____________________
Physician's Signature Date

____
Physician's Name

____________________ ____________________
Address Telephone

____________________ ____________________ ____________________
City State Zip

PHYSICIAN MUST FAX TO 501-776-5794