Benton School District
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):

_____

_____

_____

_____

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:_____

_____

_____

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:_____

_____

_____

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