

**EAST DETROIT FEDERATION OF TEACHERS
APPLICATION FOR WITHDRAWAL FROM THE SICK BANK**

Date: _____
Employee's _____

Name: _____ Building: _____

Address: _____

Phone: _____

Nature of Present Illness or Injury: _____

Last Day Worked: ____/____/____ Expected Date of Return*: ____/____/____
*Must be completed to process application

PHYSICIAN'S STATEMENT

Patient's Name _____
(Please Print)

I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE THE
FOLLOWING INFORMATION TO THE EAST DETROIT FEDERATION OF
TEACHERS SICK BANK COMMITTEE.

Employee: _____
(Signature)

Nature of illness or injury (Diagnosis): _____ If surgery is required, is it elective? _____

Probable Duration of Absence from Work: _____

Physician's Name: _____

Address: _____

Phone: _____

Physician's Signature: _____ Date: _____

*NOTE: First Year Teachers are *not eligible* for application to the Sick Bank
**PLEASE RETURN THIS FORM TO THE ADMINISTRATIVE SERVICES
OFFICE. APPLICATION WILL THEN BE FORWARDED TO
THE SICK BANK COMMITTEE**