Good Spirit
SCHOOL DIVISION

Form 460-4

VERIFICATION OF ILLNESS

Employee Authorization

I herby authorize the release of information requested to the relevant administrative personnel of the Board of Education of the School Division to verify this claim for sick leave in accordance with the collective agreement or employee handbook.

Employee Name ________________________________ Position ___________________________

Date of Birth _________________________

Instructions:

This form is to be completed for absence due to illness longer than 3 days. Please complete and return it to your supervisor as soon as possible. If you have any questions please do not hesitate to contact the Human Resources Department at hr@gssd.ca or (306) 786-4774

1. Date of Consultation: _________________________________

2. The above-named teacher has been incapable of fulfilling their job duties due to sickness:

   a) **from** _________________________ **to** _________________________ **,**

   OR

   b) **since** _____________________________ **AND** will be incapable of fulfilling their duties:

      i) for less than 4 weeks until _______________________________ ,

      OR

      ii) for at least
         - 4 weeks
         - 6 weeks
         - 3 months
         - 6 months
         - 12 months or greater

3. Date of next medical review: _______________________________

4. Has treatment been prescribed:

   Yes

   No

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Date: ____

Physician's Name: ____

Address:____

Physician's Phone Number: ____

Physician's Signature____

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