United We Care Fund

Attending Physician's Statement

This form is required for team members requesting funds for medical reasons.

Name of Patient: _____

Dates of Treatment: _____

Dates hospitalized, if any:
Date Admitted: ___ / ___ / ___
Date Discharged: ___ / ___ / ___

To your knowledge, what is the earliest date the patient was treated for this condition?

_____

Is the patient still under your care? Yes No

For what period of time will the patient be unable to work?

For what reason(s) would the patient need to miss work for this time period?

Projected date for patient to return to work: _____

_____ _____
Today's Date Typed or printed name of physician

_____
Signature of Physician