ATTACHMENT V(a)

HENRY COUNTY SICK LEAVE BANK

CAREGIVER FORM

CATASTROPHIC LEAVE

I, the undersigned licensed physician, do hereby certify that

_____has been unable to work or
(name of beneficiary employee)

has been a caregiver for a member of his/her immediate family during the following period of _____ to _____.

_____
PHYSICIAN'S SIGNATURE

_____
DATE