



Living Sky School Division No. 202
Growth Without Limits, Learning For All

5.27B
SEB II - Presumptive Period
Practitioner's Report

The information provided will be used solely to verify the date of delivery to support this claim for Supplemental Employment Benefits for the period twelve weeks post delivery.

Part 1: Identification and Authorization

LAST NAME	FIRST NAME	INITIAL
-----------	------------	---------

I hereby authorize the release of the information requested in Part 2 below to the Human Resources Department of Living Sky School Division No. 202 to verify this claim for SEB Plan benefits in accordance with Living Sky School Division No. 202 *Procedure #5.27 Human Resources: Supplemental Employment Benefits Plan for Non-teaching Staff.*

EMPLOYEE SIGNATURE	DATE
--------------------	------

Part 2: Attending Practitioner's Statement

ACTUAL DATE OF DELIVERY (M/D/Y)

Physician's Signature: _____

Physician's Name and Address:
(please print or use stamp)

Date: _____

Telephone: _____
