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

5.27C
SEB III – Extended 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 to or following the presumptive period.

Part 1: Identification and Authorization

_____
LAST NAME FIRST NAME INITIAL

Date of benefit period being claimed:

Pre delivery _____ to_____ (M/D/Y)

and/or

Post presumptive period_____ to_____ (M/D/Y)

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 Supplemental Employment Benefits.

_____ _____
SIGNATURE DATE

Part 2: Attending Practitioner's Statement

_____
EXPECTED DATE OF DELIVERY (M/D/Y) ACTUAL DATE OF DELIVERY (M/D/Y)

Pre delivery: ❑ Not Hospitalized

_____
DATE OF HOSPITAL ADMISSION (M/D/Y) DATE OF DISCHARGE (M/D/Y)

Comments regarding complications in pre delivery: _____

_____

_____

Delivery:

Comments regarding complications in delivery: _____

_____

Post delivery: ❑ Not Hospitalized

_____

DATE OF HOSPITAL ADMISSION (M/D/Y) DATE OF DISCHARGE (M/D/Y)

Comments regarding complications in post delivery: _____

_____

Other:

Other factors that may affect recovery (please specify):_____

_____

This employee has been medically unfit for duty for health-related reasons due to

Pregnancy, delivery or post delivery from _____ (D/M/Y) until _____ (D/M/Y).

This case will be reviewed _____ (D/M/Y) or next appointment to be determined ❑

Attending Practitioner:

Physician's Signature: _____

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

Date: _____ _____

_____

Telephone:_____ _____