APPENDIX P

Flint Community Schools

Doctor's Verification of Illness or Disability Form

TO BE COMPLETED BY ATTENDING PHYSICIAN

(Please Print or Type)

1. Patient's name ____ Age: ________

2. Please state:

(a) Patient's complaints:___________________________________

____

(b) Objective findings (including results of x-rays, laboratory tests, diagnostic studies, B/P, etc., if relevant):

____

____

(c) Your diagnosis: _______________________________________

(d) Brief history of illness or injury: _________________________

____

3. Give all dates of treatments by you during this period of disability:

Office or Home: ____

Hospital: ____

4. If the patient was confined as a registered bed patient in a legally constituted hospital during this period of disability, please answer the following:

(a) Name and address of hospital: ________________________________

(b) Date of admission: ___/___201___ Date of discharge: ___/___201___

(c) Date of surgery, if any: ____/____201___ Surgical procedure ____________

5. Based on your personal knowledge and treatment, how long has the patient been totally disabled solely by his/her sickness or injury so that he/she was prevented from working? From: _______/______ 201___ to and including: ______/______ 201____

6. In your opinion, is the patient's disability caused by his/her work for Flint Schools or any other employer?

YES ________ NO ________

If "YES," please explain on separate sheet.

7. If applicable, is the patient MENTALLY capable of transacting his/her personal affairs (for instance, the endorsing of checks) with the realization of the nature and consequence of his/her acts?

YES ________ NO ________

8. Has the patient recovered sufficiently to return to work?

YES ________ NO ________

(a) If "YES," give the date the patient was able to return to work:

(b) If "NO," when, in your opinion, may work be resumed? (Please do not use the terms "indefinite," "unknown," "undetermined," etc. If a definite date cannot be determined, please approximate in days, weeks, or months, how long total disability will continue from the date of most recent treatment as indicated above.)

Physician's name (please print or type):______________________________

Office address: ____

Specialty board certification: _____________________________________

Physician's signature: ____

Date completed: ___________________ 201___