McLean ISD
Extended Leave/Catastrophic Sick Leave Pool
Attending Physician's Statement

Employee Information

_____

Last Name **MI** **First Name** **Social Security**

Authorization to release for purpose of determining eligibility for benefits.
I hereby authorize the McLean ISD to receive from and/or provide medical practitioners, medically -related facilities, or insurance companies information as to any physical condition of myself relating to this claim. I understand I have a right to receive a copy of this authorization and I agree that a photographic copy is as valid as the original.

_____ _____
Employee Signature Date

_____ _____
Employee's agent Signature Date

Attending Physician's Statement

Describe in lay terms the nature of illness or injury

_____

_____

_____

Explain the short and long-term prognosis

_____

_____

_____

Dates of treatment _____

Dates of hospitalization, if any_____

Name of Hospital Admitted_____ Date_____

Address of Hospital_____

Date Discharged_____

To your knowledge, what was the earliest treatment date for this patient?_____

Is the patient still under your care? ☐ Yes ☐ No

As you understand the patient's job assignment/responsibilities with the McLean ISD, from your professional assessment of the patient's current condition can you recommend that he/she return to work at this time? Yes☐ No☐

If not, how long will the patient be unable to perform his/her job responsibilities?_____

What is the actual or anticipated date of your release for the patient's return to work?_____

_____ _____
Name of Physician (Print) Signature of Physician

_____ _____
Address Date

_____
City State Zip code

Please return this form to the patient or the patient's agent.