HITCHCOCK ISD

Catastrophic Sick Leave Program

ATTENDING PHYSICIAN'S STATEMENT

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Patient's Name (please print)

Please describe in depth, and in lay terms, the nature of the illness or injury in terms such as major/ minor, catastrophic/non-catastrophic, etc: ____

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Please give dates of treatment:____

____

If hospitalized, please complete:

Admission Date ______________________________ Discharge Date __________________

Name of Hospital ____

Address ____

To your knowledge, what is the earliest date this patient was treated for this condition: ______________________

Is patient still under your care? ______Yes ______No

How long was or is the patient expected to be continually and totally unable to work? ______________________

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Anticipate date patient can return to work: ____

Printed Name of Physician____

Signature of Physician ____ Date ________________

Address of Physician ____

Telephone Number ____