PINK FORM I

BROCKTON PUBLIC SCHOOLS

PLEASE HAVE PHYSICIAN COMPLETE AT BEGINNING OF DISABILITY

CERTIFICATION OF TEMPORARY DISABILITY OF 10 WORKING DAYS OR MORE.

Please Print

EMPLOYEE NAME_____HOME PHONE_____

POSITION_____SCHOOL_____

THE FORM SHOULD BE COMPLETED BY THE ATTENDING PHYSICIAN AT THE BEGINNING OF THE DISABILITY AND RETURNED TO THE HUMAN RESOURCES OFFICE. (43 Crescent St., Brockton, MA 02301 or fax 508-580-7091)

I, _____, do hereby certify as follows:
Name of attending physician

1. That I examined _____ on the following dates:
Name of employee
_____

2. That _____became disabled, to the extent of
Name of employee
being unable to perform his/her duties as an employee, on _____.
Date

3. That I base my opinion of his/her disability on the following facts:

_____

_____

_____
Physician should provide a detailed description of employee's condition that is indicative of the claimed disability. Please use the reverse side for additional space, if necessary.

4. Estimated time of disability:_____

Signature of Attending Physician_____Date_____

Address of Attending Physician_____

Telephone #_____

Form I

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