FORM II

BROCKTON PUBLIC SCHOOLS

RETURN THIS FORM TO THE HR OFFICE PRIOR TO RETURNING TO WORK

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 END 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 have been the attending physician for _____
Name of employee
during the period of his/her disability.
2. That I examined him/her on the following dates: _____
_____
3. The patient became disabled on: _____
Date
4. The patient was out of work and unable to perform his/her duties as a School Department employee until: _____
Date
5. The patient is able to return to work on: _____
Date
6. I base my opinion of his/her disability on the following facts: _____
_____
_____

Physician should include a concise summary of the employee's condition that is indicative of the claimed disability.

Signature of Attending Physician_____Date_____

Address of Attending Physician_____

Telephone # of Attending Physician_____

dm