HARRISON CENTRAL SCHOOL DISTRICT

Office of Human Resources, 50 Union Avenue, Harrison, New York 10528
Telephone: 914-630-3003 ■ Fax:914-835-2950

ATTENDING PHYSICIAN'S STATEMENT

DIRECTIONS TO EMPLOYEE: This form is to be completed in full by employee and the employee's attending physician. Completed form is to be returned to the Office of Human Resources.

TO BE COMPLETED BY EMPLOYEE:

Employee Name	School	Assignment

Date of Injury or Illness	Nature of Injury or Illness

If Injury – Where and how did it happen?

Employee Signature
Date

TO BE COMPLETED BY ATTENDING PHYSICIAN:

Date first consulted by patient	Date of Next Appointment	Pregnancy Yes ☐ No ☐	Expected Delivery Date

Diagnosis or concurrent condition of patient

Date injury or symptoms First appeared	Is condition related to employment Yes ☐ No ☐	Expected Treatment Duration	Date patient to return to work

Patient was confined in hospital From To	Patient was confined in house From To
Patient was totally disabled (unable to work) From To	Patient was partially disabled From To

May patient continue and/or resume normal duties without any limitations: Yes ☐ No ☐ If no, please explain

Remarks: (Any other comments regarding partial disability, work limitations, medications, etc.)

Physician's Name (Print)	Business Address	City	State	Zip

Business Telephone	Physician's Signature	Date