Turlock Unified School District

Human Resources

Employee Name: _____ Date: _____

Position: _____ Site: _____

Please Note: An authorization for release of medical information is available upon request.

Physician's Certification

1) Present Physical condition of employee: _____

_____

2) Within the duties and responsibilities listed above, are there any limitations on the employee?

_____

_____

3) Will the pregnancy present any hardship or complication for the employee? Is so, please explain:

_____

_____

4) Expected Date of delivery: _____

5) In the best interest of the employee, at what date do you advise commencement of disability leave?

_____

6) What length of time after childbirth do you usually recommend before the employee is physically able to Resume their duties and responsibilities? _____

Physician Signature: _____ Date: _____

Following the delivery, our office will contact you for a definite commitment.

Physician Name: _____ Medical License # _____

Address: _____ City/Zip: _____

Phone Number: _____

1574 E. Canal Drive • Turlock, CA 95380 • Phone 209.667.0632 ext. 2132 Fax 209.664.1157

Authorization for Release of Specified Medical Information

I, _____ hereby authorize the physician listed to release
(Employee Name)
medical information relative to the condition given below to the administration of the

Turlock Unified School District.

Physician
Name: _____ Phone: _____

Address: _____

City/Zip: _____

For the following condition:

_____

_____

_____

_____

Date: _____ Employee Signature: _____

Address: _____

City/Zip: _____

Phone: _____

7/2018 la