HOOVER CITY SCHOOLS
2810 Metropolitan Way
Hoover, AL 35243
205.439.1000

PHYSICIAN CERTIFICATION FORM

ATTENTION: THE ATTENDING PHYSICIAN **MUST** COMPLETE THIS FORM **IN FULL**

Alabama Public Schools are not eligible for Workmen Compensation and require this form to be completed for Employee Reimbursement with the Alabama Board of Adjustment

1. Name of Injured Employee (Please type or print) (Last) (First) (MI)	2. Social Security Number _____-_____-____	3. Date of Birth _____	4.Sex M____ F____
5. Home Address (Number and Street) (City or Town) (State) (Zip)	6. Telephone Number Home ( ) Work ( ) Cell ( )	7. Job Title	8. Status Full Time _____ Part Time _____ Contract _____
9. Employing Agency Hoover City Schools	10. Agency Address 2810 Metropolitan Way Hoover, AL 35243		

11. Date of Injury	12. Is there reasonable expectation that the employee will be able to return to work?	13. If "yes" on Item 12, give the date or approximate date of return
_____/____/_____	Yes_____ No_____	

14. If the employee can return to work, are there any restrictions on the employee's duties and length of time the restrictions apply?

15. If "no" on Item 12, give details for employee not being able to return to work

16. Is the attending physician referring this employee to another physician or medical agency? Yes _____ No _____
If yes, name the physician or medical agency of the referral

17. Name of Medical Facility and Address

_____

_____

_____

_____	_____	_____	_____
Signature of Attending Physician	Print Name	Telephone Number	Date

Attention Employee: This form must be returned to the principal/supervisor if medical attention was required due to injury

Revised 6.18.2013