Darlington County School District

Attending Physician's Statement

(For Medical Leave Requests)

Employee/Patient Name: _____ DOB:_____

Patient Name (if not employee): _____

Relationship to Employee (if applicable): _____

Date of onset of illness or injury: _____ First date of absence: _____

Diagnosis and Condition(s) causing absence: _____

_____

Is the condition considered to be catastrophic or severely disabling for a prolonged period?

_____Yes _____ No Please explain: _____

_____

In your opinion, is the condition caused by his/her employment? _____Yes _____ No

Anticipated dates of absence due to injury/illness: From _____ to return on _____

Is the employee able to perform any work during illness or injury? _____Yes _____ No

If the employee can work with restrictions, please list specific restrictions and the dates they are anticipated to be in effect:

_____

_____

If employee is still under treatment for the condition(s), please list the last appointment date and any future appointments scheduled:

_____

Please provide any other comments you feel are relevant to the employee's ability and expected timeframe to return to work: _____

_____

Physician Name (print): _____ Phone: _____

Office Address: _____

(Street/Box) (City) (Zip)

Physician Signature: _____ ***Date:*** _____

COMPLETED FORMS – SUBMIT TO:

DCSD Benefits Office, 120 East Smith Avenue, Darlington, SC 29532 or fax (843)398-5006