NEW BRAUNFELS ISD

ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S NAME: _____

Nature of catastrophic illness or injury: _____

_____

Please explain treatment being provided: _____

_____

_____

Check Yes or No on the lines below:

YES	NO	
_____	_____	Did the patient have an outpatient procedure?
_____	_____	Was inpatient hospitalization of the employee required?
_____	_____	If patient had surgery, was it elective?
_____	_____	If surgery was required, could it have been postponed?
_____	_____	Is patient still under your care?

To your knowledge, what is the earliest date this patient was treated for this condition? _____

How long was or will patient be continuously and totally incapacitated? _____

Date patient can return to work to full duty with no restrictions? _____

If hospitalized, please give name and dates:

Hospital Name: _____

Date Admitted: _____ Date Discharge:_____

_____ _____

Signature of Physician Date

_____

Typed or printed physician's name