



HUMAN RESOURCES DEPARTMENT

123 West Johns Road
Boerne, Texas 78006

www.boerne-isd.net

(830) 357-2000
FAX: (830) 357-2089

CATASTROPHIC LEAVE PROGRAM PHYSICIAN CERTIFICATION FORM

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of any/all medical information needed to determine eligibility into the Boerne ISD Catastrophic Leave Program.

Patient's Name (Please Print)

Patient's Signature

Date:

DIAGNOSIS: (Statement)

PROGNOSIS: (Statement)

Date condition commenced:

Probable duration of condition:

Is employee able to perform work of any kind? Yes No

Approximate date employee should return to work:

I hereby certify that the above information is true and correct and that the information provided is objective medical information relative to this patient's application to the Boerne I.S.D. Catastrophic Leave Program.

PLEASE PRINT:

Name: Physician/Psychiatrist

Signature and Title

Address:

Date:

Telephone No.:

Fax No.:

PLEASE SUBMIT THIS CERTIFICATION FORM TO: HUMAN RESOURCES DEPARTMENT