ATTACHMENT V

HENRY COUNTY BOARD OF EDUCATION
PHYSICIAN CERTIFICATION FORM

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 & Street) City/Town State Zip	6. Telephone Number Home ( ) Work ( )	7. Job Title	8. Status _____Full Time _____Part Time _____Contract
9. Employing Agency	10. Agency Address (Number & Street) City/Town State Zip		

11. Date of Injury / Illness / Surgery _____/_____/_____

12. Is there a reasonable expectation that the employee will be able to return to work? _____YES _____NO

13. If "yes" on item 12, give the date of approximate date of return. ____/____/_____

14. If the employee can return to work, are they any restrictions on the employee's duties?
If so, how long will the restrictions apply?

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

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Signature of Attending Physician	Print Name	Telephone Number	Date