

Disability Medical Form

To: _____ M. D.
(Name of Physician)

_____ has advised the Watertown City School District
(Name of Applicant)

that he/she is under your medical care. He/she is employed as a(n) _____.
(Job Title)

Please give specific medical reasons for his/her disability. A waiver of medical privilege is below.

1. Date Patient was required to cease employment _____

2. Reason required to cease employment _____

3. Date permitted to return to employment _____

4. Your reason for not permitting the patient to return sooner (please be specific)

Signed: _____ Date: _____
(Signature of Physician)

Address: _____

License Number: _____

Waiver

I hereby authorize the release of any information regarding my medical condition in connection with this current disability to the Watertown City School District.

Signed: _____ Date: _____
(Signature of Applicant)

