MEDICAL VERIFICATION
CATASTROPHIC ILLNESS/INJURY

To be completed by a physician and submitted with the DCS CATASTROPHIC LEAVE REQUEST.

Please supply ALL requested information. Attach additional sheets, if necessary, to fully explain the condition.

NAME _____

JOB TITLE _____

EMPLOYEE ID NUMBER *(Kelly Services PIN)* _____

WORK SITE _____

DATE CATASTROPHIC ILLNESS/INJURY BEGAN: _____

LIKELY, OR ANTICIPATED, DURATION OF THE CONDITION, ILLNESS, OR INJURY:

_____

Appropriate medical facts within the knowledge of the physician to substantiate the catastrophic illness/injury: (Attach additional sheets if more space is needed.)

If employee is to care for sick spouse, child, or parent, state conditions/reasons why employee must care for this person:

NAME OF PHYSICIAN *(typed or printed)* _____

OFFICE PHONE NUMBER _____

OFFICE MAILING ADDRESS: (To include City, State, and Zip)

_____

By my signature, I verify the employee named above is incapacitated due to self or family member's health condition, illness, or injury described above, and thereby unable to perform his/her job during the stated time period.

_____ _____

SIGNATURE OF HEALTH CARE PROVIDE (No stamps please) DATE

PLEASE RETURN FORM TO:
DOTHAN CITY SCHOOLS ACCOUNTING OFFICE, 1665 HONEYSUCKLE ROAD, DOTHAN, AL 36305