PHYSICIAN CERTIFICATION FORM

Escambia County Board of Education

1. Name of Injured Employee (Please type or print) (Last) (First) (MI)	2. Date of Birth / / Month Day Year	3. Sex ☐ Male ☐ Female
4. Home Address (Number and Street) (City or Town) (State) (Zip)	5. Job Title 6. Status ☐ Full Time ☐ Part Time ☐ Contract	7. Telephone Number Home ( ) - Work ( ) - Cell ( ) -
8. Employing Agency	9. Agency Address (Number and Street) (City or Town) (State) (Zip)	
10. Date of Injury / / Month Day Year	11. Is there reasonable expectation that the employee will be able to return to work? ☐ Yes ☐ No	12. If "yes" on item 11, give the date or approximate date of return. / / Month Day Year

13. If the employee can return to work, are there any restrictions on the employee's duties?

If so, how long will the restrictions apply?

14. If "no"on item 11, give details for employee not being able to return to work.

15.

Signature of Attending Physician | Print Name | Telephone Number | Date