MEDICAL CERTIFICATION OF ILLNESS

I, ____________________ a licensed physician in the state of ______________

do hereby certify that _______________________, SS# _______________ employed

as a ___________________ for the Perry County Board of Education will need to be

absent from his/her position on the dates listed below due to illness, injury, impairment,

or physical or mental condition of said employee or the need for said employee to

provide care for a member of his/her immediate family.

Immediate family is defined as:

employee's spouse, children (including step-children), grandchildren, parents and spouse's parents, grandparents and spouse's grandparents, without reference to the location or residence of said relative and any other blood relative who resides in the employee's home

Name of person whose condition necessitates employee absence: _____________

Relationship to the employee who will have to miss work: ____________________

Number of days the employee has had to miss work or is likely to have to miss work: __________

Dates or projected dates of absence: ____________________________________

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________________________	_____________	________________
Signature	Date	Telephone #