PHYSICIAN CERTIFICATION FORM
CHILTON COUNTY BOARD OF EDUCATION
Clanton, Alabama

****

Name of Injured Employee: _____
Last, First MI

SS # :____/__/ ____ Date of Birth: ___ /___ /___ Sex: ___ M ___ F

Home Address: _____
No. & St. City/Town St. Zip

Tele. No's: (Home) ( ) _____ (Work) ( ) _____ Date of Injury: ____/___/____

Job Title: _____

Where Employed :_____
School/Work Site

INFORMATION BELOW TO BE COMPLETED BY PHYSICIAN

****

Describe the injury.

****

1. Did the injury cause a disabling condition? _____ Y _____ N

****

2. If yes, is the disability temporary? _____ Y _____ N

****

3. If yes, will the disability require the employee to take time off from work? _____ Y _____ N

****

4. If yes, estimate of time away from work needed? _____Days

****

5. Give details for employee not being able to return to work.

****

6. If the employee is able to return to work, give any special conditions that may be applicable.

****

_____

Signature of Physician Print Name of Physician Tele. # Date