Bonneville School District No. 93
MEDICAL CERTIFICATION FORM

Please complete and return to: ATTN: HR Benefits Office Department
Contact the HR Benefits Office with any questions: Benefits@d93.k12.id.us ; Phone: (208) 525-4444
Return completed form via secure upload at: https://lff.d93.k12.id.us/Forms/DocUpload .

EMPLOYEE SECTION: (TO BE COMPLETED BY THE EMPLOYEE)

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned physician to release any records or information acquired in the course of my examination or treatment for the purpose of **Leave from Employment**.

_____ _____
Patient's *Legal* Name (PRINT) **Date of Birth**

_____ _____
Patient's Signature (or legal representative) **Today's Date**

_____
Patient's Phone Number

PHYSICIAN SECTION: (TO BE COMPLETED BY THE ATTENDING PHYSICIAN)

Business Name: _____
Business Address: _____
_____
Type of Practice/ Medical Specialty: _____
Telephone: (_____) _____ Fax: (_____) _____

Name of Attending Physician (print): _____

PATIENT MEDICAL FACTS

Patient's condition is the result of: □ Illness □ Injury □ Pregnancy

Diagnosis:
Is the Primary Diagnosis:
□ Pregnancy - Estimated Date of Delivery: _____
□ Other - Please Specify: _____

Subjective symptoms: _____

Was patient hospitalized for this condition? □ Yes □ No □ Anticipated Scheduled Date: _____
If yes, dates admitted: _____

Surgery(ies):

Has surgery been performed? □ Yes □ No; If No, is surgery scheduled = _____

Surgery Date:_____ Procedure: _____

2. Nature of treatment/treatment plan (including surgery, therapy, and medication prescribed, if any).

_____

_____

_____

Treatments:

Date you first treated this patient for this condition: _____

Date of onset of this condition: _____ Date of most recent treatment: _____

How often has patient been seen or treated? _____

Date of next office visit: _____

Referrals:

Has patient been referred to any other physician? □ Yes □ No

If "yes" Date(s): _____

Name of Physician: (Please print) _____

Specialty: _____

Nature of treatment for this condition:

_____

_____

WORK STATUS / EMPLOYEE RESTRICTIONS (All Fields must be completed)

Please complete the following questions regarding your patient's status.

Is your patient able to work? □ Yes □ No

Does your patient have any medical restrictions or limitations preventing his/her return to work?

_____

_____

Anticipated Return To Work Date (mm/dd/yyyy): _____

Note: This is not a release to return to work. A Fitness for Duty form must be completed and submitted before returning to work.

_____ _____

Physician's Signature Date