LOCAL EDUCATION AGENCY
PHYSICIAN CERTIFICATION FORM

1. Name of Injured Employee (Please type or print) (Last) (First) (MI)	2. Social Security Number _____—_____—_____	3. Date of Birth _____/_____/_____	4. Sex ____ M ___ F
5. Home Address (Number and Street) (City or Town) (State) (Zip)	6. Telephone Number Home ( ) Work ( )	7. Job Title	8. Status ___ Full Time ___ Part Time ___ Contract
9. Employing Agency	10. Agency Address (Number and Street) (City or Town) (State) (Zip)		
11. Date of Injury _____/_____/_____	12. Is there a reasonable expectation that the employee will be able to return to work? ____ Yes ____ No	13. If "yes" on item 12, give the date or approximate date of return. _____/_____/_____	

14. If the employee can return to work, are there any restrictions on the employee's duties? If so, how long will the restrictions apply?

15. If "no" on item 12, give details for employee not being able to return to work.

16.

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