MEDICAL CERTIFICATION STATEMENT
(EMPLOYEE'S OWN SERIOUS ILLNESS)

Name of Employee: ____

Date condition began: ____

Estimate of probable duration of the condition: ____

____

Diagnosis of the serious health condition: ____

____

____

Statement of the regimen of treatment prescribed for the condition (including estimated number of visits, nature, frequency, and duration of treatment; treatment by other providers; and whether in-patient hospitalization is required):

____

____

____

Explanation of the extent to which the employee is unable to perform the functions of his/her job: ________________

____

____

Is the employee unable to perform work of any kind?

_______ Yes

_______ No

If the answer is yes, please explain: ____

____

Is the employee unable to perform the essential functions of his/her job?

_______ Yes

_______ No

If yes, please explain: ____

____

______________________________	______________________________
Date	Signature of Healthcare Provider
	______________________________
	Type of Medical Practice
	______________________________
	Specialization, if any
	______________________________
	Office Telephone Number

MEDICAL RELEASE

I authorize the release of any medical information, necessary to process my leave request, by my physician or other healthcare provider to the Caney Valley school district.

______________________________	______________________________
Date	Patient's Signature