PHYSICIAN'S STATEMENT FOR ABSENCE
DUE TO MEDICAL REASONS

MEDICAL UPDATE

TO BE COMPLETED BY MD/NP/PA ONLY

SEND TO: DIRECTOR, HEALTH SERVICES, 725 Harrison St., Syracuse, NY 13210
Phone: 435-4145; Fax: 435-4859

This is to certify that I have examined ________________________________(________________)____________________
First *Init.* *Maiden* *Last*

_________________________________/_______________________________ on ______________________, 20_____
Job Title *School Department* *Date*

_______________________________ ____________________________ ________________________________
Employee ID # *Home Phone #* *Cell Phone #*

Workers' Compensation: ☐YES ☐NO Claim # _________________________________

for (**diagnosis**) (**REQUIRED**)_____________________________________ and find that, in my opinion , this person is physically and/or emotionally **unable** to return to active duty in the Syracuse City School System.

Reason(s) why employee unable to return to work: ____

Original date of onset of absence: ________________, 20_____ **Approximate date of return:** __________, 20______
(PLEASE ESTIMATE RATHER THAN USE UNKNOWN OR INDETERMINATE).

FOR USE OF HEALTH SERVICES DIRECTOR ONLY

Absence commenced on ___________________________
Comments: _______________________________________

☐ Approved ☐ Disapproved

____
Signature/Health Services Director

____
Date

____
Physician's Stamped Name

____
Physician's Signature

____
Address/Street and Number

____
City/State/Zip Code

____
Telephone

____
Date

I hereby authorize ___________________________________ to disclose the health information described above to Medical Director, SCSD, 725 Harrison Street, Syracuse, NY 13210

____ ______________________
Employee Signature *Date*

Absences extending past the date indicated by your medical provider on your Absence Due to Medical Reasons form will require the completion of a Medical Update form.

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