PHYSICIAN'S STATEMENT FOR ABSENCE DUE TO PERSONAL ILLNESS, OR INJURY

TO BE COMPLETED BY PHYSICIAN ONLY

Rev. 7/08

SEND TO: DIRECTOR, HEALTH SERVICES (725 Harrison St., Syracuse, NY 13210)
(435-4147 or 435-4146) FAX – 435-4859)

This is to certify that I have examined ______________________________(_______________)____________________________
First *Init.* *Maiden* *Last*

________________________/____________________________________ on ____________________________, 20 _______
Job/Title *School/Department* *Date*

________________________ ____________________ ________________________ Workers' Compensation __________ NO
Employee ID # *Home Phone #* *Cell Phone #*
Claim # ______________________ __________ YES

for (**diagnosis**) ____, 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.

Date of onset of absence: ________________________, 20 _____

* *Prognosis as to duration of sick time required:*
(PLEASE ESTIMATE RATHER THAN USE "UNKNOWN") ____

Comments : ____

FOR USE OF HEALTH SERVICES DIRECTOR ONLY

Absence commenced on ____________________________

Comments: ______________________________________

____

☐ Approved ☐ Disapproved

____
Signature/Health Services Director

____
Date

____
Physician's Name (Please Print)

____
Physician's Signature

____
Address/Street and Number

____
City/State/Zip Code

____
Telephone #

____
Date

* It is the policy of the Syracuse City School District to grant sick leave benefits during periods of maternity or personal illness disability in an amount equal to, but not exceeding, unused accumulated sick leave for the period of actual physical disability and not for any additional time off which is a matter of convenience or family or personal preference. The District reserves the right to evaluate the recommendations and conclusions of an employee's private physician, and also has the sole and exclusive discretion to determine the legitimacy of each claim processed.

I hereby authorize ________________________________to disclose the health information described above to Dr. Richard P. Kulak, FAAFP, SCSC, 725 Harrison St., Syracuse, NY 13210

____ ____________________________
Employee Signature ***Date***