**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.**



**Rev. 08/2020**