TROY CITY SCHOOLS

Physician Certification of Catastrophic Illness or Injury

Name of Patient_____ Social Security #_____

I hereby certify that the above listed individual is a patient of mine and is suffering an illness or injury which will cause the patient to be absent from work for an extended period of time which is estimated by me to be at least one of the following.

_____ One Week _____ Two Weeks _____ Three Weeks

_____ One Month _____ Permanently _____ Indefinitely

_____ Other _____

Comments:_____

_____

Signature of Physician: _____

Date: _____

Print Physician's Name: _____

Physician's Address: _____

_____

Please return this form to the Chairperson of the *Sick Leave Bank*