CALDWELL COUNTY SCHOOLS

DOCTOR'S CERTIFICATION FORM

Employee's Name: _____

Patient's Name & Relationship to Employee (if different from employee):

_____

I hereby certify that the above patient is under my care and it will be necessary for the above employee to be out of work beginning on _____ (MM-DD-YYYY)**.**

☐ **The employee is released to return to work with no restrictions on _____.** (MM-DD-YYYY)

☐ **The employee will be re-evaluated on _____** (MM-DD-YYYY) **and at that time a return to work will be issued or an extension of leave will be requested.**

☐ **The employee will be able to return to work on _____** (MM-DD-YYYY) **with the following restrictions _____**

_____

_____.

_____ _____

Physician's Name (Print) **Telephone Number**

_____

Name of Practice/Office

_____

Physician's Address **City** **State** **Zip**

_____

Physician's Name (Signature) **Date Signed**

Please mail or fax this form to:

Benefits Coordinator
Caldwell County Schools
1914 Hickory Blvd. SW, Lenoir, N.C. 28645
(828) 728-8407 x 159
(828) 728-0493 Fax

Revised: January 2, 2012